THE CANADIAN NURSE

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VOLUME 51 • NUMBER 11
MONTREAL

Highlight for
NOVEMBER 1955

NURSING REQUIREMENTS
Flanagan & Herdan

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THE DOORWAY
MONTREAL NEUROLOGICAL
INSTITUTE

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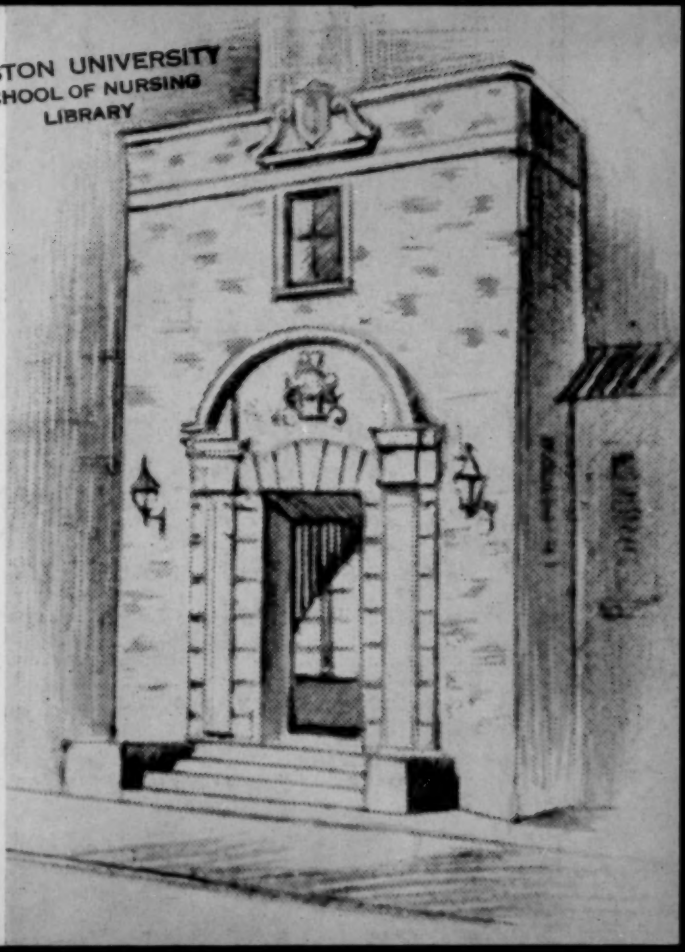

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L'Infirmière Canadienne

VOLUME 51 **NUMBER 11**

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

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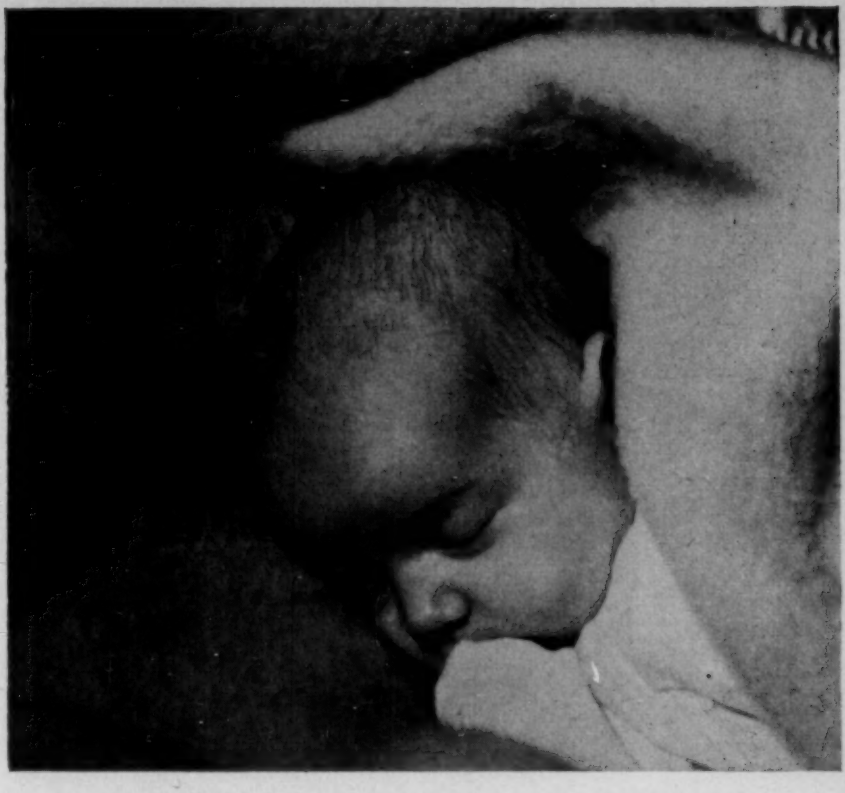

What is a baby? "A baby is a star or prode in the eye of a father — a lullaby in the heart of a mother. A baby is a smile that makes someone else smile back. Bigger and better dreams are built because of a baby. What other blossom unfolds so sweetly? What other blossom brings such joy to a family?"

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Between Ourselves

How long does it take a nurse to give an oral medication, a penicillin injection, to turn patients who cannot of their own volition change their position in bed? These and a hundred other functions performed millions of times every year in every hospital are the jobs that nurses do. A few hospitals have made detailed ***time studies*** of these functions. It is our privilege to present in this issue a preliminary report on one such analysis that has been carried out over a period of three years at the Montreal Neurological Institute. **Eileen C. Flanagan** and **Irene M. Herdan** collaborated in assembling these data from the huge stack of observational reports that were accumulated.

So, in answer to the questions raised above we learn that the average time required to give a dose of medicine is 1¼ minutes. The preparation of an injection of penicillin, giving it to the patient and cleaning up the equipment afterward took an average of 4½ minutes for each injection.

Because of the special kind of patients cared for at the world famous M.N.I., the turning of patients is frequently a fairly complex procedure. "Patients who require turning usually receive this care once every hour." As many as five persons may be necessary to perform this function correctly. Does a picture form in your mind of the problems *you* might have to locate four other persons every hour to turn one helpless patient?

Our authors deliberately refrained from including any information relative to costs in their article though these have all been computed. With their permission we want to tell you just a few of the totals they have reached. With an average daily occupancy of 120, they found that it cost them $6,000 a year for the time nurses or nursing assistants sat feeding patients. The figure for turning and posturing of patients, as mentioned above, soared to the unbelievable amount of approximately $40,000 a year. Nursing time spent in assisting with the encephalograms was valued at around $1,800.

Read this immensely interesting study carefully.

* * *

The advance ***registration forms*** for the 1956 Biennial Convention are included in this issue. We suggest that you get yours into the mails fairly promptly. As was noted editorially in our July issue, the most economical living accommodation will be available on the campus of the University of Manitoba. Since the space there will be limited to 550 nurses, if you have to watch your pennies (and who doesn't?) cut out the form, complete the details, and get it into the mail, with your registration fee, as quickly as possible. The space will be allocated on a "first come, first served" basis so get your application in early.

In the case of student nurses, we suggest that registrations be made on the basis of the probable number who will be sent. It is obviously impossible to fill in the names of the girls who will be going at this early date but it should be possible to reach a decision as to the probable number. Would it not be a wonderful stimulus to every school of nursing if each was represented by at least one student? Get busy right away, student councils, figuring out money-raising projects to pay your representative's expenses.

* * *

The day we put the article by **Geneva Lewis** into the basket for November copy, we received a letter from the director of the McGill School for Graduate Nurses announcing that three ***evening courses*** were being made available to nurses in the Montreal area this winter. The letter opened with a significant sentence. "Many requests from graduate nurses have come to us to extend opportunities for evening courses." There is the essence of this interesting development — nurses made themselves vocal in respect to the need they felt for opportunities to learn. We hope that nursing groups in other communities where university facilities are available will join in urging the establishment of similar opportunities. Those who are working at some distance from the university centre need not bemoan their exclusion from participation. Miss Lewis found a way to travel from Welland to Buffalo — and that includes crossing the border each time, too!

History is just gossip that has grown respectable with age.

— SIDNEY J. HARRIS, in *Chicago News*

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Manufacturer—Nordic Biochemicals Ltd., Montreal. *Distributor:* Anglo Canadian Drug Co., Oshawa, Ont.; The Stevens Companies, Winnipeg, Calgary, Vancouver.

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Administration—Apply a liberal amount over the surface of the joint and the surrounding skin area 3 or 4 times a day. The application of heat has been found to enhance absorption.

CREMOMYCIN

Manufacturer—Sharp & Dohme Division of Merck & Co. Ltd., Toronto.

Decription—Each 30 cc. of pleasant-tasting suspension contain: Sulfasuxidine succinysulfathiazole 3.0 gm., kaolin, colloidal 3.0 gm., pectin 0.3 gm., neomycin sulfate 300 mg.

Indications—Treatment of specific and nonspecific diarrheas.

Administration—Infants (15 to 25 lb.) — ½ to 1 teaspoonful 6 times daily. Children (35 to 65 lb.) — 1½ to 2½ teaspoonfuls 6 times daily. Adults — 1½ to 2½ teaspoonfuls 6 times daily.

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Administration—25, 50, 100 mg. daily depending upon condition being treated.

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Administration—One in the morning and one at bedtime. In particularly resistant cases one every eight hours may be desirable.

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Description—Contains: Dipropylene glycol salicylate 50%, methyl nicotinate 1%, ethyl nicotinate 1%, in a water-washable base.

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Administration—Apply regularly night and morning for ten days about a three and a half inch strip of ointment in a thin layer over a **large** skin area, preferably but not necessarily on and around the sore part, **without rubbing.** About ten minutes after application, the skin should redden, at which time **very gentle** rubbing will promote absorption of the ointment through the skin. If area becomes sensitive, change site of application. Repeat ten-day treatment as required.

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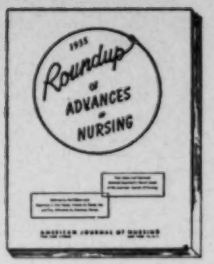

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Description—Each 10 cc. contains: Butabarbital 16 mg., scopolamine methylbromide 2.5 mg. in alumina gel.

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Administration—Usual dose is 10 cc. in water between meals and on retiring. In determining the dose for each patient, the physician may find the optimum for some may be as high as 15 cc. and for others as low as 5 cc.

BIDORMAL

Manufacturer—Allen & Hanburys Co. Ltd., Toronto.

Description—Each tablet contains: Pentobarbitone sodium 90 mg. (in outer coat for immediate action), and butobarbitone 60 mg. (in inner core for delayed action.)

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Manufacturer—Tailby-Nason Company of Canada, Ltd., Montreal.

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Indications—Eczema, psoriasis, acne vulgaris, seborrheic dermatitis.

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THE CANADIAN NURSE
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A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 51 NUMBER 11

MONTREAL, NOVEMBER, 1955

The New Look

IT IS A RARE OCCASION when our daily newspaper does not carry a reference to the opening of a new hospital, hospital wing, or plans for such construction. In a recent address Hon. Paul Martin, Minister of National Health and Welfare, indicated that federal assistance had been approved for no less than 800 individual building projects. Such an extensive program must of necessity affect nurses and nursing.

The changes that have taken place in Canadian hospitals since the turn of the century make a very interesting study. The primary objective of the early hospital was to provide nursing and medical care for the acutely ill. The school of nursing developed at that time was designed to meet the need for nursing service. The curriculum reflected this need. An understanding of the care of the mentally ill apparently was not considered of pressing importance. Psychology, mental hygiene and psychiatric nursing care found little place in the teaching program until the 1930's. With the number of mentally ill reaching vast proportions, many general hospitals are now including a psychiatric unit in their building programs to help provide the required treatment and care.

Apart from those disabled with mental illness, it is estimated that Canada has 975,000 persons suffering from some form of permanent physical disability. The advisability and advantage of restoring as many of these individuals as possible to a productive place in society is easily seen . . . for economic reasons, if for no other. The development of rehabilitation centres has received governmental support. Funds have been made available so that hospitals may expand existing facilities or plan for them. The modern nurse is becoming increasingly aware of the rehabilitative aspects of nursing care.

A visit to a hospital ward provides a picture of yet another change occurring in society as a whole, that is the shift in population age. A similar visit a few years ago gave the general impression of youth. The reverse is quite evident today. The trend is towards chronicity and extended periods of convalescence due to the number of elderly persons hospitalized. To ease the strain on active treatment beds, consideration must now be given to the need for provision of special

facilities for those with long-term or chronic illness. Nursing care is an important factor under such circumstances. The nurse must be prepared to deal with the special problems encountered.

One of the aims of the National Health Program is to encourage the creation and expansion of facilities to help keep people out of hospital. Hospitals are assuming a more important rôle in community health services. Financial assistance again has been made available for the development or expansion of outpatient departments where diagnostic measures and simple treatments may be obtained. Home Care plans have been developed by some hospitals with the intention of reducing the necessity for hospitalization. Keeping people out of hospital! This indicates perhaps most clearly of all how the aims of our hospitals have changed. The rôle of the nurse has expanded accordingly.

The school of nursing as a means of providing nursing service is giving way gradually to the school as an educational institution. Those who are concerned with revision of curricula and nursing research have this aim in mind. It is felt that the end result will be the preparation of nurses who are better equipped to meet the demands of modern society for professional services — J. E. MacG.

In the Good Old Days

(*The Canadian Nurse* — November, 1915)

"The two most striking signs of change and development this year have been the growth of progressive ideas pertaining to the control of liquor traffic and the Woman's Suffrage movement. This is particularly true in the four western provinces. Before long, let us hope, these progressive movements will carry the more conservative and less progressive eastern provinces along and we shall have prohibition and Woman Suffrage on a dominion-wide basis."

* * *

"The private duty nurse has no ultimate authority to appeal to and no association to back her in cases of trouble. Registration of all nurses would be a means of bringing these women under the protection of an authoritative body."

* * *

"Nursing service is available to the rich who can afford to pay the price; it is provided for the very poor because their need has captured the imagination and interest of the public. It seems to many persons that the time has certainy come to think more earnestly about the health protection of the sober, industrious, average householder. Unfortunately, the great bulk of the nation is at the mercy of such unskilled care as small purses can command.

"I have frequently noticed that only the most thoughtful members of the medical profession realize the value of highly skilled sickroom care in the interval of their visits. Between the hazy attitude of mind of the physician and the desire of the middle-class family not to exceed an expenditure commensurate with its funds, all kinds of young females in white aprons and caps pass muster as nurses and are left in positions of grave responsibility.

"Hourly nursing is a basis on which individuals of smaller pûrses can club together to pay for the services of a well qualified nurse who would move from patient to patient giving required care but being a financial burden to none."

Influence

You say the little efforts that I make
Will do no good:
They never will prevail
To tip the hovering scale
Where injustice hangs in balance.

I'm not sure
I ever thought they would
But I am prejudiced beyond debate
In favor of my right to choose
Which side shall feel
The stubborn ounces of my weight.

— Mrs. D. W. Overstreet

A Preliminary Study and Analysis of Nursing Requirements in Neurological and Neurosurgical Nursing

The Montreal Neurological Institute

EILEEN C. FLANAGAN, B.A. *and* IRENE M. HERDAN, B.N.

A TIME STUDY AND ANALYSIS of nursing care required by neurological and neurosurgical patients, *per se*, seemed to us to be an urgent need. This study was undertaken to help us determine our future requirements, to assess our present organization, staffing and patient needs, and to assist in setting up a nursing budget.

All figures and observations that have been available previously from neurological departments have shown that more hours of nursing per patient seemed to be required than for the patients in the general medical and surgical services.

It is well known that the staffing of any nursing department is becoming increasingly more difficult. Frequent personnel changes, periodic staff shortages, and the high cost of nursing services are only a few of the

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problems common to all hospitals today. Since neurological patients make great demands on nursing service these factors are serious considerations.

This study has been carried out over the past three years. Credit must be given to all members of the nursing staff for the cooperation, time and effort they gave to the study. Nursing care has been surveyed many times in general and children's hospitals and full use has been made of the findings in all these studies.

In the survey carried out by the Nuffield Provincial Hospital Trust, "The Work of Nurses in Hospital Wards, Nuffield Trust 1953" nursing care is explained as follows:

> The reason for giving nursing care lies in the necessity for satisfying the needs of the patient . . . The ordinary physical needs of a patient in a hospital ward are the same as those of any individual outside and the same basic facilities have to be provided to secure his physical well-being and comfort, and to prevent infection. The main difference between the two is that the patient in hospital may be more helpless and have to have done for him things that ordinarily he would do for himself. "Basic Nursing" is the term that will be used to describe those nursing duties having their origin in the physical needs of the patient. The fact of his being in hospital means that, as well as physical needs, the patient has medical needs which must be satisfied. "Technical Nursing" will be used to describe the care given as a result of the disease from which he is suffering. Finally, there are social or psychological needs . . . and the satisfaction of these needs is an essential part of his recovery.

The purpose of our study was to find out (a) what nursing care was needed — basic nursing; (b) what nursing care was provided — technical nursing.

Method of Approach

Estimating the *nursing care needed* by patients was difficult and time-consuming. Nearly 400 recordings were made of nursing care given to individual patients durings separate 8-hour periods. Patients were grouped according to physical disability into four groups and 60 studies (20 for each 8-hour period) were done for each of the four recognized disability groups.

The *nursing care provided* was studied by standard statistical methods, using:

a. The number of nursing staff hours available to each patient.

b. The proportion of those hours which consist of nurses care and auxiliary staff care.

Limitations of the Study

1. A study could be extended to compile data on all nursing done during one year. However, it has been proved that an adequate sampling will give a reliable picture of the entire time.

2. While recordings were made of patient care, the staff knew their work was being observed by a former nursing supervisor and the effect was counteracted in several ways:

a. Street clothes were worn by the observer.

b. The staff was told that the study was to record the nursing care needed by the patients, not to judge the performance of the individual members.

c. Recordings did not mention any names, therefore it seemed less important to impress the observer.

3. Since recent time studies are available on the nursing of children and infants, the only work done in the children's ward was to time such procedures as encephalograms, twist drill holes and ventriculograms. Unless these are done under general anesthesia, more staff is needed to help with small patients than with adults.

The Nursing Care Needed by Patients

Selection of patients for studies of nursing care proved more reliable on the basis of physical dependency than of diagnosis. The time needed to give care was estimated from the average time taken by staff to provide this care. This meant timing of practical, not ideal situations.

Degree of Physical Dependency

The amount of nursing a patient requires depends both upon the extent to which he can care for himself and the nature of his illness. In daily consultation with head nurses the patients were grouped as follows:

Group 1: Patients are up and about and can look after themselves. They require care of their bedside unit, serving of meals and fluids, medications, treatments and tests.

Group 2: Patients are up most of the time but require some help due to physical or mental handicap, weakness of some extremity, seizure or confusion.

Group 3: Patients are confined to bed most of the time, can help themselves to some extent, but need help with nearly all functions.

Group 4: Patients are completely or almost completely dependent. Post-operative, disoriented, unconscious, confused and paralysed patients are included in this group which is relatively larger in neurosurgical wards than in those of any general hospital.

In addition, the timing of nursing care showed that about one out of every 20 patients classed under Group 4 needed nursing care far in excess of the maximum of "300 minutes in 24 hours" quoted in the Nuffield study. Any patient requiring more than four hours of nursing staff time during at least two consecutive periods was put aside into "Group 5." Not enough figures were obtained to classify such patients separately, but one example will illustrate the problem. One patient needed 10 hours 6 minutes of nursing between 3:30 and 11:30 p.m. The patients who needed so much care over a period of days included:

Those suffering from severe brain damage following accidents;

Spinal injury due to accident;

Tetanus;

Prolonged unconsciousness due to brain tumors.

Patients requiring such care are a strain on the evening and night staff who may have to nurse them as well as look after a busy ward. A few such patients have private nurses but the ward staff is called upon to help the special nurses for long periods of time.

The psychological aspect of illness also influences the amount of nursing care needed by patients. To allow for this, a few patients were upgraded through one group if they required extra care due to confusion, restlessness or a tendency to wander. No patient was graded beyond Group 4 on this account.

Nursing Care Needs

Nursing care needed in 24 hours by patients in different groups of physical dependency:

Group 1: 1 hour 14 minutes (1.2 hours). Day: 48 minutes, evening: 18 minutes, night: 8 minutes.

Group 2: 2 hours 4 minutes (2.1 hours). Day: 60 minutes, evening: 44 minutes, night: 20 minutes.

Group 3: 2 hours 44 minutes (2.7 hours). Day: 85 minutes, evening: 46 minutes, night: 38 minutes.

Group 4: 6 hours 53 minutes (6.9 hours). Day: 172 minutes, evening: 125 minutes, night: 115 minutes.

These were observations of nursing care given directly to the patient. The time taken to prepare and serve meals was included. Other activities not timed were: charting, reporting on patient's conditions, telephone and other conversations with medical staff and visitors; maintenance of supplies and equipment; servicing dressing rooms.

The number of patients falling into each degree of physical dependency is as follows:

Group	*No. of Patients*	*Per Cent*
1	1214	25
2	762	16
3	1103	23
4	1696	36
Total	4775	100

N.B. Children were excluded from these figures as the data on them would have required a full separate study.

Hours of Nursing Needed per Patient

The average nursing care given at the bedside is shown to be 3.7 hours or 3 hours 42 minutes per patient in each 24 hours. (The serving of meals

and diet was the only activity away from the bedside which was included in the above figure.)

A detailed time and motion study which would cover all staff activities would have raised the above figure by approximately one hour per patient. (Head nurses on each ward agreed to this figure.) This would bring the hours actually expended in care per patient up to 4.7 hours or 4.42 minutes. To provide this care a unit of 25 patients requires:

1 Head nurse

3 Assistant head nurses (1 each period)

2 Dressing room nurses (7:30 and 3:30 periods)

9 Staff nurses 5 — 2 — 2 (covering the three periods)

6 Nursing aides 3 — 2 — 1 (covering the three periods).

2 Male orderlies are required for the 7:30 period for the men's units, and one each for the 3:30 and 11:30 periods. Male orderly assistance is needed for the women's units to help lift patients in and out of the continuous baths.

Timing of Recurrent Ward Activities

Meals: The serving of 20 meals was timed on each of three floors. The serving of breakfast, dinner and supper showed only small differences for each meal. Cooking of breakfast and more elaborate tray serving showed the tray turn-over on the private floor.

On the ward floors the nursing staff spent an average time of 4½ minutes per tray served. The longest time required was 8 minutes per tray. The fastest trays were served in 3½ minutes per tray.

On the private floor, the trays were served in 6 minutes per tray. Variations in time (4 minutes to 9 minutes per tray) were due to the menu (breakfasts were served more quickly when boiled eggs were planned than when bacon had to be cooked.)

The above time does not include feeding of helpless patients.

Feeding patients: An average of one out of every five patients has to be fed at meal time. On three different days of observation almost one-half of the patients in one ward had to be fed. Time required for this was from 6-41 minutes per patient. Average time: 13 minutes per meal.

Diet: Serving of drinks between meals was timed 20 times on each floor. Drinks served were fruit juices, ginger ale, milk and cocoa (at night). Large variations were found here in the length of time required. However this was mainly due to the time required by different nursing aides in preparing the drinks, handing them to patients, then collecting and washing the dishes.

Giving oral medications:

Average time required: 1¼ minutes.

Longest time required: 2½ minutes.

Shortest time required: ¾ minute.

Comment: These timings do not apply in the children's ward. Great difficulties are sometimes encountered here. One assistant head nurse commented "It took 23 minutes to make J. (aged 3 years) swallow her dilantin this morning."

Giving penicillin injections: Seven different nurses were timed five times in the morning and in the evening. The preparation of injections, giving them to patients and cleaning of equipment were timed together:

Average time required: 4½ minutes per injection.

Longest time required: 7 minutes.

Shortest time required: 3½ minutes.

Cleaning of equipment took nearly half the time in each of the above cases. Differences in timing were a matter of individual variation.

Daily reports: No attempt was made to survey the "paper work" done at each nurse's station.

Patient records consisted of charting at least twice daily: temperature, pulse and respiration; medications, treatments, tests and the patient's progress. Fluid intake and output measurements, recording of seizures observed and blood pressure charting are often required in addition to the above routine. Vital signs may need checking as often as every 15 minutes. This is time-consuming and can be a problem to the night nurses.

Ward reports are written twice daily by the nurse in charge. These cover the main items of change in the patients' conditions and take from 30-60 minutes in 24 hours. Carbon copies

are collected by the supervisor on duty during ward visits.

These written reports are supplemented by oral reports at the change-over times for nurses at 7:30 a.m., 3:30 p.m. and 11:30 p.m. The entire incoming staff is briefed — this takes from 30-60 minutes in 24 hours. Nurses starting work later in the morning — any time between 8:00 a.m. and 11:00 a.m. — usually read the written report for themselves. Reporting at change of period still takes place twice in half the wards in the morning. The head nurse receives the report from the night nurse and then relays it to all her staff.

Written reports take up 30-60 minutes of the time of the nurse in charge during each 24 hours.

Oral reports require 30-60 minutes in 24 hours. As they are attended by all graduate and student nurses and most nursing aides, the time involved is considerable, yet, so far no more effective way has been found to relay the necessary information.

Turning of patients: Patients who require turning usually receive this care once every hour. Turning patients who cannot change their position in bed was timed 200 times; 44 different patients were observed. One to five staff members carried out this procedure. Two people were the team most often involved. Fifty-seven turnings which included changing draw sheets were not used as data. One single patient classed in Group 5 required 388 minutes (6.4 hours) of combined staff time for four turnings between 3:30 p.m. and 11:30 p.m. This was exceptional and while not used for timing is mentioned for interest.

200 turnings	*time required*
10 minutes or less	64%
11-30 minutes	29%
30-60 minutes	5%
over 60 minutes	2%

Average staff time required for one turning: 12 minutes.

Nasal feedings: Forty nasal feedings were observed. They required 8-50 minutes each. Average duration: 13 minutes. A nurse was present in 32 cases. A nursing aide assisted in 4 cases. Doctors worked alone in remaining 4 cases.

Head dressings: Twenty head dressings were observed. They required 16-41 minutes each.

Average time: 24 minutes.
In dressing room: 18 minutes.
Cleaning of equipment: 6 minutes.

Back dressings: Twenty back dressings were observed. They required 13-29 minutes each.

Average time: 19 minutes.
In dressing room: 13 minutes.
Cleaning of equipment: 6 minutes.

Infected dressing (brain abscesses): In the authors' opinion, too few were observed for an adequate sampling. However, 11 were seen and each took 40-65 minutes of the nurse's time. Eight of the eleven dressings were done between 3:30 and 11:30 p.m. These are always done after all clean dressings are completed for the day, although they are carried out in a special dressing room used for this purpose only.

Injections for trigeminal neuralgia: Eleven injections were observed on wards each of which lasted between 40 minutes and 1 hour 45 minutes. One nurse was required each time. Nine of these injections were done between 4:00 p.m. and 12:00 m.n.

Evaluating individual performance: An attempt was made to compare the length of time required for the performance of bathing, a procedure carried out by both nurses and nursing aides. The head nurse assigned the same two patients to different members of her staff on successive days. (These were both long term Group 4 patients with no changes in their daily routine). The timing of baths in minutes:

Staff member	*Patient No. 1*	*Patient No. 2*
R.N.	28	34
R.N.	27	32
R.N.	35	35
R.N.	29	35
R.N.	29	26
R.N.	34	53
R.N.	53	49
Nursing Aides		
N.A.	40	42
N.A. (Trained Attendant)	26	28
N.A.	40	44
N.A.	49	44
N.A.	54	59

N.A.	49	53
N.A.	46	42
N.A.	60	67
N.A.	62	54

Average time:

Nurses: 31 minutes

Nursing Aides: 49 minutes

A very large percentage of our patients are given their baths in the continuous baths, not in bed. This is time-consuming since no patient is left alone. They are given one or two a day and for periods of one-half to two hours.

Encephalograms: Forty encephalograms were observed. The time spent varied with the number of staff involved. An encephalogram takes at least two hours of nursing staff time.

In the dressing room: 1 nurse and 1 orderly approximately 60 minutes.

In x-ray department: 1 nurse 40 minutes.

Cleaning equipment: 1 nursing aide 20 minutes.

Operating room nurses, when available, watched the patients in the x-ray department. This happened in one out of four cases observed.

One out of three encephalograms need one or two nurses in addition to the staff mentioned above during the dressing room procedure. Post-graduate and undergraduate nursing students who have to observe or assist with this procedure are usually available for help in these cases. Extra staff is needed where children are patients and no general anesthetic is given. Here a nurse or aide replaces the orderly.

Twist drill and ventriculogram: Twenty procedures were observed. They can be carried out following each other or twist drill holes may be made earlier on the same day or on the evening preceding it. The time involved in either case does not vary much.

Average nursing staff time: 3 hours 10 minutes.

In the dressing room: 2 nurses 120 minutes.

In x-ray department: 1 nurse 40 minutes.

Cleaning equipment: 1 nursing aide 30 minutes.

Operating room nurses also watch these patients while in the x-ray department in about one quarter of cases. Additional help (one nurse) may be needed during the procedure in the dressing room in one-half of the cases. Post-graduate or undergraduate nursing students are often available for this.

Factors Accounting for High Hours of Nursing Care

1. The high incidence of very ill patients:

a. Post-operative patients nursed in recovery rooms or side rooms.

b. Unconscious patients.

c. Paralyzed patients.

d. Confused or restless patients to be watched constantly.

e. Patients with major seizures requiring observation in order to avoid accidental injury.

f. Incontinent patients.

g. Infectious diseases, i.e. meningitis.

2. The amount of care required by patients: the following are recurrent time consuming practices:

a. Feeding patients.

b. Hourly and two hourly turnings.

c. Changing of incontinent patients.

d. Checking of vital signs — as often as every 15 minutes.

e. Observation and writing up of seizures.

f. Isolation technique.

g. Continuous baths.

3. Urgent administrative and medical requirements of neurological and neurosurgical patients:

a. Rapid turn-over of patients results in a high percentage of acutely ill patients, and adds to the administrative load.

b. Early ambulation, which involves getting many almost helpless patients out of bed once or twice a day over fairly long periods of time.

c. High incidence of emergency and accident patients.

d. The admission of patients at any time required by their medical condition, and by their arrival and departure from long distances by planes and trains.

e. Treatment of outpatients in ward dressing rooms, e.g., for injection of trigeninal nerve or for dressings.

f. The fact that major procedures

like encephalograms, twist drills and ventriculograms which are carried out in ward dressing rooms are peculiar to this type of hospital.

The length of time required and the nursing care given to our patients has been the main object of this study. Observation periods covered enough time to include days of 99% bed occupancy during 1953-54-55.

One of the outstanding findings has been the thorough nursing care given to the very ill patients in Groups 4 and 5, the experienced nurses spending the same number of hours with their sickest patients on the busy and on the slack days. On busy days or when the available staff hours were short of requirements the less ill patients had to be given more care by auxiliary staff. The fact that not all of them were trained workers and the difficulty of supervising their work at such times is one of the problems in using workers less skilled than nurses.

Personnel

Graduate staff: The majority of the staff has taken the course in the Institute or in other neurological centres and the excellence of their work proves that it is neither economical nor satisfactory from a nursing point of view to have staff who are not specially trained. This was demonstrated when we were obliged to increase the staff temporarily to adjust to the opening of the new wards, and used nurses not prepared to nurse neurological patients. It meant poorer nursing and called for a high degree of supervision on the part of trained staff.

Estimate of Required Staff:

Nursing staff required for 125 patients in order to maintain 4.7 hours per patients in 24 hours, 365 days a year (2 units 25 = 50, 5 units 15 = 75).

Director of nursing	1
Assistant director of nursing	1
Supervisors — wards	1
dressing rooms	1
instructor	1
Night supervisor	1
Assistant night supervisor	2
Head nurses	7
Assistant head nurses	16
(½ time bedside care)	
Dressing room nurses	6
General staff	30
Post-graduates	16
(½ time bedside care)	
Students	8
Nursing aides	23
Relief nurses	6
	120
Operating room supervisor	1
Asst. room supervisor	1
Asst. anesthetic nurse	1
Asst. x-ray nurse	1
Scrub nurses	6
	130

Costs

We have estimated the yearly cost of all the procedures that have been described and timed. The figures are not given because of the differences in hours of duty and salaries, the difference in layout of wards and the distribution of patients in hospitals. Our findings are available to anyone desiring more detailed information.

Summary

1. It would appear that the minimum average hours of bedside nursing care which should be given to a patient suffering from a neurological or neurosurgical disease is 3.7 at the bedside (exclusive of other duties the nurse has to perform). Approximately one further hour per patient seems to be needed for other duties on the ward. This brings the estimated minimum total number of hours required per patient to 4.7 hours in a 24-hour period. The number of hours required per patient in a surgical ward of a general hospital is estimated to be 3.5 hours (National League for Nursing Education, 1948).

2. The direct bedside nursing care of 3.7 hours per patient is needed as follows during the three periods: day: 1.7 hours, evening: 1.1 hours, night: 0.9 hours.

3. The average hours of bedside nursing provided per patient were found to be 4.6 hours in 24 hours, and the total care was 5.6 hours. This included patients requiring 24-hour care, i.e. Group V, and the infants and children.

4. Considerable variation in the amount of nursing care hours required from day to day was evident because of emergencies and the number of post-operative patients.

5. On the whole, the night period appears to be satisfactorily organized from the point of view of rotation of staff and nursing provided.

6. There is a tendency for shortage of staff to occur more frequently during the evening period, i.e., 3:30-11:30 p.m., because of post-operative patients and emergencies which call for an increase of staff at this period and a further analysis of the nursing load.

7. Very ill patients are given efficient care by experienced nurses.

8. A better application of the team concept of nursing is needed to ensure adequate care of the moderately ill patient.

9. At certain times of the year we had, perhaps, too frequent changes of general staff nurses but the head nurses, the supervisory staff, and the operating room staff were extremely stable.

The report which we have presented covers the nursing care in a very active Neurological Institute, handling a large number of acute conditions and many accidents. It is also an intensive university research and teaching unit. It is very well equipped with the latest and most efficient apparatus, beds, instruments, dressing and treatment rooms, all of which are a great asset to the nursing service. However, the real crux of good neurological nursing care is competent bedside nursing, expert observation, psychological understanding and eternal patience. This calls for good basic nursing experience plus the qualities which fashion the expert, and requires constant care, guidance and interest on the part of head nurses and supervisors.

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Good News from Nova Scotia

At their annual meeting last June, the Registered Nurses' Association of Nova Scotia gave unanimous approval to a resolution to submit a ballot to their membership seeking a decision on the question of the inclusion of the subscription to *The Canadian Nurse* in the annual dues.

Ballots were, accordingly, sent out during this past summer. The result was eminently gratifying. By a "substantial majority" the members approved this professional step for both active and associate members.

Nova Scotia thus becomes the eighth province in which the registered nurses have thrown the full weight of approval behind their own professional journal. By arrangement, they will begin receiving their copies, under this new plan, commencing with the March 1956 issue.

Acquired Heart Disease

ARTHUR VINEBERG, M.D.

SURGERY OF THE HEART may be divided into two large groups namely:

1. Surgery of congenital lesions of the heart.
2. Surgery of acquired heart disease.

In a previous article the former was discussed; the latter is the subject of this article.

Congenital and acquired heart diseases have one similarity, namely, the presence of a mechanical condition interfering with normal heart function which theoretically should be correctable by surgery. Unfortunately the mechanical heart defects which are acquired after birth are the result of disease. The disease not infrequently involves more than one portion of the heart. This makes the surgical treatment of acquired heart lesions more complicated and the results of treatment somewhat less satisfactory.

Surgery of acquired heart lesions will be discussed here under the following headings: (a) Traumatic, (b) constrictive pericarditis, (c) valvular, (d) coronary artery insufficiency.

TRAUMA TO HEART

Much has been written concerning heart wounds. Until comparatively recently they were considered to be hopelessly fatal. They may be grouped as follows: Contusion of the heart; penetrating wounds of the heart; foreign bodies within the heart chambers.

Contusions of the heart: A severe blunt blow to the precordium may injure the heart. The so-called "steering wheel" injury is the most common cause. There may be no associated thoracic cage damage. Rarely one of the cardiac chambers is ruptured; more often there is damage to the ventricular myocardium; coronary artery damage is said to occur. Heart contusions may be overlooked. For this reason the probability of cardiac injury following thoracic cage injury should be kept in mind.

Penetrating wounds of the heart: Caused by stabbing, bullets, etc., they occur infrequently in this country. Blood escapes from the lacerated heart chamber into the precordial sac where it may compress the heart. The amount of blood and the speed with which the blood accumulates within the precordial sac is dependent upon the size and location of the heart wound and determines to some extent the outcome. Increasing amounts of fluid within the precordial sac compress the heart resulting in *cardiac tamponade*, i.e. *cardiac compression.* The heart is literally *choked* in that adequate venous return flow is retarded and the left ventricular output consequently decreased.

Cardiac tamponade may be recognized by: (a) A small quiet heart, (b) rising venous pressure, (c) falling arterial pressure. Unless the compression of the heart is relieved the patient will die. Thus the treatment of penetrating heart wounds is immediate relief of cardiac tamponade, replacement of blood loss and closure of the laceration.

If the instrument responsible for the damage is still present it is best to leave it in the heart, plugging its own wound, until the wound can be safely sutured.

CONSTRICTIVE PERICARDITIS

This is a condition in which the heart is encased and compressed by thickened, diseased pericardium which is usually tubercular in origin. Generally the constricting, thickened and possibly calcified pericardium partially obstructs the vena cavae. This results in elevation of venous pressure and may produce liver enlargement as well.

This is the third in the series of articles on cardiac surgery written by Dr. Vineberg, who is associated with the Royal Victoria and the Jewish General Hospitals, Montreal.

The cardiac output is diminished. The disease develops gradually and can be recognized by: (a) A small quiet heart, (b) elevated venous pressure, (c) enlarged liver and ascites.

The treatment is to remove the encircling constrictive pericardium. It is necessary to free both ventricles and clear away constricting bands from superior and inferior vena cavae.

Diseases of the Valves

The commonest cause of valvular disease is rheumatic fever. During the course of the disease various heart valves become inflamed. The disease process in the mitral, tricuspid and aortic valves may produce a loss of valve substance thus creating insufficiency. In other cases fusion of valve leaflets occurs with resultant narrowing of the valve causing valvular stenosis. In many patients there are multiple lesions.

Mitral stenosis: This is a condition in which the mitral opening is reduced in size. This may be congenital in origin or be caused by disease — usually the sequela of rheumatic fever. The valve leaflets are affected by the disease. The extent varies from slight scarification to complete fusion at the commissure. The orifice may be narrowed to pencil size. The result is similar to the scarification that fuses the lateral part of the human lips producing obliteration of the corners of the mouth in some burns about the face.

In addition to the narrowed mitral opening movement of the valve leaflets is impossible. Blood has to be forced by the left atrium into the left ventricle through the narrowed opening. This leads to left atrial hypertrophy — dilation and back pressure in the pulmonary veins. The lungs become congested. The right ventricle in time develops decompensation. It dilates and tricuspid insufficiency results. Actually, if the condition is not relieved, the continuation of backward pressured results in increased pressure in the right atrium and vena cavae.

The symptoms of pure mitral stenosis vary from fatigue and slight dyspnea, to orthopnea, pulmonary congestion and signs of right heart failure. In far advanced cases there is ascites, liver enlargement and swelling of the lower extremities.

Through surgery it is possible to re-open the stenosed mitral valve and in many instances restore valve function. This is accomplished, usually, by entering the left auricular appendage either with the finger or with a knife. The fused valves are split along their commissure — lateral and medial respectively — in an attempt to restore valve function. If the finger alone is used, it is referred to as a digital fracture of the commissures. The procedure, whether performed with the digit or by knife, is termed *mitral commissurotomy.*

Excellent results have been obtained by this operation. The results depend upon three factors:

(a) *The stage of the disease* and its effect upon the chambers of the heart, the pulmonary capillary bed, and the liver. Thus the result of relieving mitral stenosis in a patient in whom there is *early* pulmonary hypertension will undoubtedly be better than if one waits until there is severe right heart failure with its attendant ascites, liver enlargement and lower extremity edema.

(b) *Condition of the valve at time of surgery:* Rheumatic heart disease, as we have said, varies greatly with reference to its effect on the mitral valve. When there has been severe disease, the valve leaflets are markedly thickened and there is shortening of the chordae tenineae due to scarification. There may be subvalvular stenosis caused by fusion of the thickened chordae tendineae and of the papillary muscles. Commissurotomies can still be performed in such patients and separation of the chordae tendineae and papillary muscles accomplished. Unfortunately, even though satisfactory separation of valve leaflets may relieve the stenosis, one cannot expect as good a result as when the leaflets are sufficiently well preserved to permit normal leaflet function after commissurotomy.

(c) *Adequate commissurotomy:* To some extent this depends upon the skill and experience of the surgeon.

Results of mitral commissurotomy: Mortality varies from 5 per cent in the early to 31.7 per cent in the far advanced cases. Excellent results can be

expected in over 75 per cent of those that are not too far advanced and, even in the latter group, about 40 per cent are markedly improved. It is indeed most gratifying to watch patients who have been more or less chronic invalids return to full and active lives.

Mitral insufficiency: This is a condition in which the mitral valve is defective permitting blood to flow from the left ventricle into the left atrium during systole. There are two types — one in which there is loss of valve substance and the other in which the entire valve ring or annulus is stretched. Varying degrees of mitral insufficiency may be present when there is mitral stenosis. In fact one of the most difficult problems in diagnosis at present is to ascertain the degree of mitral regurgitation in the presence of mitral insufficiency.

The treatment of mitral insufficiency is at present still entirely unsatisfactory.

Aortic stenosis: There is a narrowing of the aortic valve caused by rheumatic infection. This narrowing may interfere with coronary artery flow producing anginal pains. The left ventricle is overworked and eventually becomes decompensated. Aortic stenosis can be relieved with comparatively low mortality in properly selected cases. There is a very high mortality in cases showing left ventricular failure. In general one can expect good results in approximately 20 per cent of the patients. The valve is approached either through the left ventricle or through the aorta — a specially designed instrument is introduced and the valve cracked.

Aorta insufficiency: The treatment of this condition, like that of mitral insufficiency, is still unsatisfactory and has not been attempted by many surgeons.

It is possible to open more than one stenotic valve at the same operation. Thus mitral and aortic stenosis can be treated simultaneously as can mitral and tricuspid stenosis.

The Pregnant Woman and Mitral Stenosis: Thousands of women in the past have lived barren lives because, in their youth, rheumatic fever injured their heart valves. Previously it was necessary to terminate pregnancy when heart failure developed due to mitral lesion. This is no longer necessary. The pregnant woman withstands mitral commissurotomy as well if not better than a non-pregnant woman. We have performed mitral commissurotomy as late as the seventh month of pregnancy and obtained both a living baby and a very much improved mother. Certainly it is best to consider valvular surgery prior to pregnancy, when indicated and when possible.

Thanks to the ingenuity of many men and women of this and preceding generations, people no longer die or live as invalids because of heart trauma, constrictive pericarditis, mitral stenosis and other valvular lesions. The successful treatment of these diseases represents a tremendous forward step in the alleviation of human suffering.

Unfortunately these heart diseases represent a rather small proportion of all heart ailments. The vast bulk of heart conditions are caused by coronary artery disease and are associated with coronary artery insufficiency. This subject will be discussed in a later article.

Sound Waves May Heal Arthritis

Sound waves we cannot hear, known as ultrasonic waves, may provide an improved method of treating diseases such as bursitis, arthritis, skin infections and ulcers. The device which generates the sound waves is applied directly to the skin, in contrast to the standard ultrasonic machines for therapy which beam the rays through the air just as an ordinary radio transmitter does. The waves generated by the new machine penetrate so deeply they even go into the bones. Although the ultrasonic energy raises the temperature of the tissues within the body, the patient does not feel the heat. His skin is covered with mineral oil for protection.—(ISPS)

La perfection est la raison d'être. — BOSSUET

Coarctation of the Aorta

LAURA M. NORDIN

DEFINITION

COARCTATION OF THE AORTA consists of a congenital narrowing of the arch or of the descending portion of the thoracic aorta. It may be corrected surgically by the excision of the stenosed portion with an end to end anastomosis of the aorta.

ETIOLOGY

Coarctation occurs most commonly at a site just distal to the origin of the left subclavian artery or at the attachment of the ligamentum arteriosum (a fibrous cord constituting the remains of the ductus arteriosus of the fetus). Some believe that coarctation represents a continuation of the obliterative process which normally occurs in the ductus. It is a congenital heart disease of the acyanotic group — there is no interference with the oxygenation of the blood. Pulmonary blood flow is normal or may be increased. There are two pathological varieties.

Infantile type: The narrowing occurs over a long segment. This is usually associated with other abnormalities and is not, as a rule, compatible with prolonged life.

Adult type: Constriction is localized to an area of a centimeter in length or less.

Complications: These are due to hypertension and the mechanized strain at the narrowed area. The most dangerous are:

Cerebral hemorrhage
Cardiac failure
Rupture of the aorta
Subacute bacterial endocarditis. (Individuals with coarctation rarely live past the third decade.)

SIGNS AND SYMPTOMS

These depend on the obstruction to the flow of blood and the compensating phenomena which result in attempt to overcome it. This results in:

1. Hypertension in the upper part of the body.
2. Low blood pressure and absence of arterial pulsation in lower extremities.
3. Cardiac enlargement.
4. Development of collateral circulation which will be made evident by enlarged scapular vessels, intercostals (shows in notching of the ribs) and internal mammaries. Pulsating vessels can usually be felt.

If the stenosis is severe and collateral circulation is inadequate the patient may have serious and disastrous results. He will give evidence of hypertension, headache, sense of weakness and fatigue. In later stages retinal hemorrhages and vascular disease of the cerebral and coronary vessels occur causing cardiac and cerebral symptoms such as, cerebral hemorrhage, coronary occlusion with infarction or rupture and aneurysms of the aorta or other vessels.

Mr. McLelland, a 34-year-old sheet metal worker was admitted to hospital in February. The following signs and symptoms were found:

Hypertension in the upper part of the body.

B.P. right arm 196/98, left arm 194/90.

Pulsations in carotid — normal

Pulsations in subclavian — prominent

Pulsations in intercostal spaces — present.

For a number of years he had complained of throbbing headaches, chiefly occipital, occasionally frontal, which might be present at any time of the day. Fundi showed corkscrew type of arteries but no hemorrhage or exudates.

Low B.P. in lower extremities, right leg 130/110, left leg 134/104

Femoral arteries
Dorsal Pedes
Abdominal Aorta
} no pulsations felt.

Since childhood he had complained of pain in the lower thighs and calves on exertion, there being a feeling of squeezing as if they were in a vise.

Miss Nordin is the operating room supervisor at Shaughnessy Hospital, Vancouver.

Cardiac enlargement

Examination of Mr. McLelland also revealed dyspnea on exertion, slight cyanosis of the fingertips but no clubbing, no ankle edema or chest discomfort. Angiocardiogram did not demonstrate coarcted area. Nothing could be found to suggest other congenital defect.

Pre-operative Care

Diagnostic aids which may be employed pre-operatively are ballistocardiograms and electrocardiograms which give evidence of myocardial damage or of other cardiovascular anomalies. X-rays help to indicate the presence of abnormalities. Angiocardiographs, the venous injection of a dye, usually 70% Diodrast, followed by serial films of the aortic arch and its branches often will demonstrate a coarcted area.

Pre-operatively the care is much the same as for other surgery. The general condition of the patient must be good. All sources of infection must be eliminated. A restful night is ensured before surgery by the use of sedatives, usually nembutal or seconal. To prevent the patient from going to the operating room in a state of apprehension and anxiety, and also to aid in smooth anesthesia, a pre-operative hypnotic is used. Complete blood work is done, the patient also being cross-matched for blood. At least four bottles should be on hand for an adult. Because of the nature of the incision and the removal of ribs, the patient should be instructed in exercises of the arm. General anesthesia is used, the position is lateral with left side up. A large skin area is prepared by shaving and is painted with ether and zepherin.

Operative Procedure

A lateral incision is made and the thoracic cavity exposed. One or two ribs are usually removed to give better exposure. The aorta is dissected free by tying off the various vessels, the intercostals where necessary and the ligamentum arteriosum. The aorta may be lifted from its bed by means of tapes. The coarctation clamps are applied and the stenosed area excised. Type of anastomosis used depends on the length and position of the stenosis.

a) End to end suture of the aorta.

b) Anastomosis utilizing the left subclavian artery, used when the stenosed segment is too long for end to end anastomosis. In such cases the subclavian artery may be divided at the apex of the pleura and brought down for end to end anastomosis. There are no ill effects on the arm because of the collateral circulation which has been established.

c) Recently, arterial grafts have been used successfully to replace segments of aorta removed. The ultimate fate is not yet determined but immediate results are excellent. The grafts are collected from human beings four to six hours after death. They may be stored in Tyrode's fluid for a period of one month or packaged in Cellophane bags and frozen in carbon dioxide ice, in which case they may be kept for several months.

Continuous everting mattress suture of fine silk is used for the anastomosis. When complete the clamps are removed from the distal end, and if the anastomosis holds satisfactorily the clamps on the proximal end are gradually released (over a period of 2-3 minutes.)

The chest is aspirated and the pleural cavity closed. Because of the extent of the wound, there is always some accumulation of sero-sanguineous fluid after operation and intercostal drainage by tube is usually provided for several days.

End to end anastomosis was the procedure chosen for Mr. McLelland. The stenosed area was approximately 1 cm. long and situated very near the subclavian artery.

A large set of instruments is needed for this procedure. Because of the long incision and vascularity of the area a large number of forceps will be used. Rib removing instruments and chest retractors will be necessary. Long instruments will be needed when the chest has been opened, also the special artery clamps such as the Bulldog, Blalock and Potts. Very fine sutures, usually 4-0 or 5-0 should be on hand. A little table should be set

up with stimulants which might be needed in case of cardiac arrest. These solutions would include

Heparin (prevents thrombosis)
Adrenalin 1:1000
Procaine hydrochloride 1%
Calcium gluconate 10%
Xylocaine 2%
Normal saline

These medications should be available when the anesthesia is started and should remain sterile until the patient leaves the operating room.

Immediately post-operatively, these patients may have to be nursed with the foot of the bed elevated, and on oxygen therapy, to combat any signs of shock. Liquids may be taken as soon after the operation as tolerated, and solid foods may be given 24 hours following surgery.

Some patients are able to dangle their legs or stand at the side of the bed the 2nd evening and be up in a chair on the 3rd or 4th day. By the end of the week they should be walking about for short periods. The blood pressure is watched closely as a return to equal blood pressure in the leg and arm indicate good operative results.

Mr. McLelland was discharged 18 days following surgery, with every reason to believe that the operation was a successful one.

The Role of the Nurse in the Treatment of Alcoholism

MARY T. TONER, M.A.

THE ROLE OF THE NURSE in treatment of alcoholism is a subject about which little has been said. This is not surprising when we reflect that the concept of alcoholism as a treatable condition is relatively new. One might say that the nurse is one of the latest arrivals in this field. All nurses inevitably encounter the condition of alcoholism in the course of their nursing careers but in the past their reaction to persons suffering from the disorder has been similar to that of the public in general, i.e., the alcoholic is a person with no will-power, a shiftless individual and a hopeless proposition. Moreover, in the general hospital situation the alcoholic was considered to be a nuisance, not only to the staff but to other patients as well.

While the nursing curriculum has been vastly broadened to embrace a large variety of disciplines within the last ten years, and notwithstanding the fact that the concept of mental health, into which alcoholism naturally falls, has been integrated with many of these disciplines, information of a useful sort concerning alcoholism has been marked by its absence. Yet it is becoming increasingly obvious that nurses do have something to contribute to this field, and many may achieve satisfaction in working with alcoholics.

It might prove useful to attempt to point out the role the nurse plays and, furthermore, could play in working with the alcoholic patient. The experience of the Connecticut Commission on Alcoholism at its Blue Hills Hospital indicates that under proper conditions the nurse's role in the rehabilitation process can be extremely important. Her contribution to the care and even eventual rehabilitation of the patient, is by no means a minor one, but ranks equally with the contribution of other specialists working with the problem drinker.

What kind or what type of nurse can work successfully and satisfactorily with the alcoholic patient? In the course of experience it has become

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Miss Toner is nurse supervisor at Blue Hills Hospital, operated by the Connecticut Commission on Alcoholism.

clear that personnel with appropriate personality traits are hard to find. It is becoming more and more apparent that anyone working with the alcoholic patient must possess characteristics that will prevent him from developing feelings of omnipotence, domination, or exploitation of the patient to serve his or her own emotional needs. It will be of interest, therefore, to consider first the treatment and care of patients at Connecticut's Blue Hills Hospital which is designed solely for the treatment of patients suffering from alcoholism. This may give a clearer picture of the manner in which patients react to such a setting and point out along the way some of the characteristics or traits nurses need to have if they are to be able to contribute their best to their care and treatment.

In a hospital such as Blue Hills, all patients are in difficulty because of their drinking behavior. Most of them quite willingly admit this. A few say — because they truly see the situation that way — that drinking is not really a problem and are inclined to blame their difficulties on a variety of reasons or people. In one way, therefore, the task of the staff at the hospital is simplified. Staff knows and the patients themselves know that they have encountered some sort of difficulty or are in trouble because of their drinking. In the light of present knowledge, little can be done for any patient until he is able to admit to himself that something is wrong. Treatment cannot begin, so to speak, until the patient and the treatment are brought together. So, in a sense, the very presence of a patient in a hospital such as Blue Hills may be said to constitute the beginning of treatment of his drinking problem. It should be pointed out here that this does not apply to the individual with a drinking problem who is admitted to a general hospital for the treatment of some other specific malady.

It has been said that the alcoholic patient is "challenging, elusive, and frightening." To care for alcoholics day in and day out makes it mandatory for the nurse to understand the dynamics of addictive drinking and to be fully cognizant of the fact that with alcoholics they are dealing with individuals who have emotional problems and who may exhibit bizarre behavior that requires patience and understanding. The nurse, entering this field, finds that it is necessary to undergo a radical change in her thinking. Nurses, in common with the medical profession and the public at large, have become accustomed to think, and therefore to work, in what might be termed a "milieu" of a *cure* for the patient. In an age of so-called wonder drugs, highly developed surgical procedures, and all of the vast benefits which have helped in prolonging man's life span, nurses have come to anticipate not only a high percentage of *cure,* but of rapid and certain recovery from illness and disease. Let us take, for example, the treatment of pneumonia. Older nurses, can remember when that disease was so often a fatal one and will also remember the amount of highly skilled nursing care required by patients with pneumonia. It is surprising to some of them to see how lightly this disease is regarded today. In most cases they consider the average case of pneumonia as no more serious than the common cold. And indeed, with the advent of more and more efficacious antibiotics this is usually the case.

To give another example — early ambulation and, as a result, rapid discharge from the hospital in surgical, obstetrical and even orthopedic cases, have oriented nurses to the concept of rapid and certain cures for many conditions. We do not see this sort of thing with the patient suffering from alcoholism. To date there are no specifics, no wonder drugs, no magical techniques which will effect a certain "cure" for the alcoholic patient.

The nurse working with the tubercular patient can have, in a certain sense, a better understanding of caring for the alcoholic patient than the nurse working in other fields. Tuberculosis, like alcoholism, is a long-term proposition and subject to relapses. Perhaps this would be more clear if an example were given. Let us say Mr. X is admitted to a hospital for alcoholics. He comes in acutely intoxicated. He may have been drinking for a period

of three weeks. Consequently he is in poor condition nutritionally. He is severely dehydrated and generally ill. He is restored to physical health through rest, food, vitamins and other medications and treatments. Usually by the end of two weeks he has made a marked, sometimes even striking, physical improvement.

The uninitiated nurse, unware of the dynamics operating in this individual, may easily assume the patient to be cured. This man is discharged with an appointment made at an outpatient clinic for his follow-up care. But, six weeks later he is readmitted to the hospital in the same condition as when he was first seen. This may happen whether or not the patient ever contacted the outpatient clinic, and it might happen in a shorter period than six weeks. When it does happen it can be extremely disturbing to a hospital nursing staff who thinks in terms of the general hospital type of patient mentioned above.

What nurses have to learn — and it is not easy — is to think in terms not of cure or total recovery from alcoholism but rather in terms of improvement. If a man or a woman, who had never managed to remain sober for a period of more than a few days eventually, through hospitalization and follow-up treatment, accomplishes sobriety for four months, it can be regarded as a staff accomplishment and as a gain to the patient himself, his family and his whole social adjustment. Until the nurse can accept emotionally as well as intellectually this concept she is bound to find working with the alcoholic a discouraging and disheartening procedure.

Again, the nurse working with the tubercular patient is in a unique position to share this feeling with the nurse working with the alcoholic patient where both so often are faced with the problem of relapses in their patients. Discouraging as relapses may be, they do not mean that the nurse in either field lessens her efforts to again help her patients to health. Nurses have to start where the patient is, accept him and his behavior, and attempt to understand it. His behavior — his acting out — is in terms of his whole life situation. How the patient sees himself and how he perceives the nurse in relationship to himself is of extreme importance.

It is of equal importance that the nurse be ever on the alert to discover what role, besides that of a nurse, the patient is assigning to her in his emotional life of the moment. This will, of course, be determined by his own past experiences with women helpers — wives, mothers, sisters. In one instance a patient considers a nurse to resemble his mother whereupon the nurse becomes for the moment an illusory and most cherished figure. In another instance the patient may consider the nurse to resemble a hated aunt who brought him up under rigid, disciplinary conditions and for whom he holds a conscious fear or hatred. These concepts of resemblance are usually on a completely unconscious level. In other words, the patient may interpret a gesture, a mannerism, a name or his own unconscious desires and needs as something onto which he can pin his anxiety or in some manner make, what will be for the moment, a satisfactory transference.

To put it another way, these patients in the course of their recovery are going to have to relive many of their early life experiences. In order to do this they are of necessity bound to work out their problems at successive levels with key figures in their lives. Many times the nurse will find herself cast in one or more of these roles. Stable, mature nurses who are not too easily upset by such experiences with patients are needed. Obviously not every nurse can make the adjustments necessary to work with alcoholics nor would she want to. But for the nurse who is interested in helping the alcoholic, satisfactions can be obtained. However, she should be fully aware of what difficulties she will face before she seeks employment in the field of alcoholism rehabilitation.

The alcoholic is prone to blast away at a nurse for any or no reason. The nurse must be able to accept this without letting it disturb her equanimity or make her angry. This is not easy. Alcoholics have been scolded, nagged and punished. Their feelings of guilt are all-pervading. They come into the hospital expecting "more of the

same." It well might be that the first contact they have in the hospital is with the nurse. Her calm acceptance of the patient, her gentle understanding, her completely accepting attitude can do much in restoring some of the sufferer's lost esteem. This is the beginning of treatment in the hospital and reflects the importance of the nurse's role in the therapeutic process.

The alcoholic patient is usually a demanding sort of individual. In his own twisted and tortuous sort of reasoning he figures it is more blessed to receive than to give. This desire to *get* on the part of the patient is manifested in many ways. It may be in demands for medication. For instance, the patient may approach the nurse an hour before his medication is due and demand, literally *demand*, that he be given the medication prescribed for him. When the nurse reminds him that his medication is not yet due, or tells him it is now only three o'clock and not four, he may attempt to satisfy his need for getting by requesting an aspirin for a suddenly developed headache. It is well to remember that most of these mechanisms are operating on what can be regarded as a childish level. Nurses have to subsume a certain amount of immature behavior on the part of these individuals and be prepared not only to understand it but to be able to cope with it in a kind but firm manner. The nurse, to function well in this field, needs to be patient by nature as well as nurture.

During their hospitalization, when they achieve sobriety, many patients become extremely restless. They cannot seem to settle down. When they have completed their work assignments, which are part of the treatment, and there is no other immediate activity scheduled such as group meetings, films, or occupational therapy, they pace the corridors endlessly. They seem to have to be on the move and such activities as reading, writing letters, or just simply resting do not suffice to calm their troubled spirits.

In any group of patients there are some who want to engage the nurse in conversation at every possible opportunity. Constructive use of such opportunities in nursing has too long been neglected. This has been due, in the main, to just plain pressure of work and lack of focus on the patient's needs. Nurses need to talk with patients and to listen to what they have to say. Here again it becomes apparent that nurses need to know how to listen constructively and to understand what the patient is saying — what he is really trying to convey by his conversation. Through appropriate encouragement and a non-judgmental, accepting attitude the nurse may be able to learn much about the patient which can be of great help to the physician in his treatment approach.

The nurse can make a contribution to effective understanding of the patient through intelligent observation of patients' reactions to treatment, toward environment, to other patients, and through her contacts with visiting relatives and friends of the patient. Odd bits of information about the patient and his situation which he recounts casually either to her or to other hospital personnel can be important and which he may have hesitated to talk about to his physician, considering them too trivial. Such information, however, can be important and may throw needed light upon and give life to the material collected in the formal interview.

Alcoholics are prone to interpret a refusal of any of their demands or requests as rejection. Nurses need to know how to refuse without rejecting. This is a skill that is not easily learned but to be able to do it skillfully presents to the nurse an opportunity to help patients to communicate with her, with the other patients, and to participate in the treatment program. As Peplau has said, "Perception of the role in which the patient casts the nurse, identification of the difficulty that is being worked through, and sustaining a working relationship that develops awareness in the patient of how he feels are nursing skills."

The nurse needs orientation to other disciplines. It goes without saying that every nurse is well aware of her relationship to the doctor. However, it often happens that she is not too clear on her relationships with other members of the team. Too often she is unaware of the role played by the so-

cial worker, the psychologist or by the outpatient clinic to which the patient will return upon discharge from the hospital. Yet the nurse is most apt to be the very person the patient will question about these things. Caplan writes, "The nurse's specialized function arises from her very special position in relation to her patient, and this is a role which is not open to any of the other specialists except under atypical conditions. The chief characteristic of this position is closeness." He lists closeness in space, closeness in time, sociological closeness, and psychological closeness and goes on to say,

> The nurse moves freely between the two worlds of patient and specialist . . . too often the wealth of information she has collected about a case remains locked inside her and is not passed on to the other specialists. There are many reasons for this, but one thing is certain, which is that both the nurse and the other professional workers ought to try to work out a more efficient method of insuring this essential communication.

Access to this essential communication can be furthered through regular staff meetings attended by the staff physicians, nurses, social workers, occupational therapists and by others who have pertinent information which would be helpful in understanding the patient and his problems.

Let us consider briefly the nurse in other fields and how she can best serve the interests of a patient whose drinking problem is complicated by the presence of another illness. The patient in a tuberculosis sanitorium is a case in point. In a case such as this the staff may be aware of a drinking problem but experience has shown that it is unlikely that the patient will mention it. Or, if he does admit to it he is apt to minimize it since he feels, and quite rightly, that his drinking problem is not his primary problem at the moment. In many such cases when the nurse confronts the patient with some truth about himself he may experience severe anxiety, panic, or rage. Therefore it seems best that the physician should initiate a discussion of the patient's drinking problem which the patient will more readily accept from that source. Once this has been accomplished the nurse may then be able to encourage the patient to discuss it with her at which time she can point out the help that is available to him.

Another opportunity for helping these patients may present itself to the nurse through contact with his family or relatives. Families are often deeply concerned about what is happening to the patient and to them. They do not know where to turn. Many times a great deal can be accomplished by introducing the relative to a clinic or other treatment resource that may be available for help with the patient's drinking problem. It is very often through such interest and assistance that the nurse gets the patient to take the first step toward admitting his drinking problem and toward accepting treatment of it.

As already stated the nurse, no matter what her field of specialization, is almost certain at some point in her career to encounter the problem of alcoholism. Her ability to cope with the problem will depend to a large extent on her understanding of its dynamics and of the proven techniques that can effectively help patients to accept treatment of the disorder. Obviously this can only be brought about by education. It is encouraging to note that a few schools of nursing have already begun to incorporate material on alcoholism into the curriculum. This has probably been brought about by the fact that nurses, especially those engaged in the fields of public health and industrial nursing have been impressed by the need to know more about the problem and what they can do about it. The nurse is a late arrival in this field and therefore has no established pattern to follow.

Much more attention by our schools of nursing to the major health problem of alcoholism and to the needs of nurses for an understanding of the disorder is essential so that nurses may be equipped through training to fulfill the great potential which is theirs to contribute importantly to the rehabilitation of the alcoholic and to the prevention of alcoholism.

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A Project in History of Nursing

PATRICIA RYAN *and* RUTH FAWSON

DURING OUR PRECLINICAL PERIOD we undertook a very interesting class project in our History of Nursing course. We worked industriously dressing twelve tiny dolls as nurses — each one representing a different era of nursing from the beginning of the Christian period to the present day Sister of Charity of the Halifax Infirmary.

The work of dressing the dolls and gathering information about the lives of the different personalities was divided among all the students of the class. Since so few of us can be classed as seamstresses, the task of making the costumes was left to those who are adept in using the needle and thread.

At the completion of the course the dolls were placed on display for the benefit of the faculty and members of the alumnae association. At this presentation the orators of the group gave a glimpse into the personalities portrayed by our miniature nurses. Now we will tell you a little about each.

The authors are students of the Halifax Infirmary School of Nursing.

An interesting project.

Our first doll was dressed as a nurse of the early Christian period from about 1-500 A.D. Doll number two wore the habit of the Augustinian nun. The Augustinians were the first purely nursing order of the Church. The third doll was dressed as a Knight Hospitaller of St. John of Jerusalem, a military monk group of the time of the Crusades. The Maltese Cross worn by this order is the cross which adorns the pin worn by the graduates of the Halifax Infirmary. The fourth doll wore the royal robes of a Hungarian princess, Elizabeth of Hungary. St. Elizabeth is often referred to as the Patroness of nurses. The Mendicant Orders of the late Middle Ages were represented by a doll dressed in the habit of the Franciscan Friar. The Franciscans stimulated interest in public health especially in relation to the control of leprosy, so prevalent at that time. The Dark Period of our history was not overlooked, and a doll was dressed to depict the nurse of this period.

Mademoiselle Jeanne Mance, the lovely pious French lady, who came to New France to care for the sick took her place among our miniature nurses. A very interesting doll was the one dressed as a Sister of Charity of the Seventeenth Century. The Lady of the Lamp, who needs no introduction to members of the nursing profession, took her place also.

One of our dolls was dressed to represent a student nurse of the Halifax Infirmary in the year 1908 and portraits of this first class were closely scrutinized to obtain the exact details. Presenting quite a contrast was the doll dressed as the student of the year 1955. Our last doll became a Sister of Charity of the Halifax Infirmary. In this century the Sisters of Charity are found all over the world and as a monument to their initiative and foresight stands our own hospital.

In preparation for the display, one of our classmates persued the pages of an issue of "What They're Saying About Nursing," It was interesting to hear what Mr. and Mrs. Citizen think of nursing.

A study of History of Nursing has revealed that the spirit of nursing — of kindness and devotion to duty — has been kept alive by good nurses throughout the ages. We became more aware of the great influence that the nursing profession has both socially and spiritually in the world today. With this thought in mind we can truly say — "To be a nurse is to walk with God."

Throughout the ages from the times of the ancient Egyptians, signs have been utilized as a means of indicating a man's occupation or craft or his place of business or residence... Professional signs were utilized on the tombs of the catacombs where a physician was portrayed by a cupping-glass. Incidentally, one surgeon at Pompeii added to the sign above his door a warning that he did not allow credit — "Eme et habebis."

Many signs were adopted by apothecaries and alchemists... and although the sign of the "Mortar & Pestle" came to be used exclusively by apothecaries, most of the signs used by the alchemists incorporated some indication of the mythical properties of the ingredients they used... The dragon of medieval alchemy seems to have been the emblem of Mercury, as Mercury, like the dragon, could "eat its own poisonous tail," and extract therefrom a valuable medicine — the useful drug calomel . . .

The qualities attributed to the Unicorn caused the animal to be used as a sign . . . by chemists... The horn of the unicorn was considered to be an antitode for all poisons, and that the unicorn, by dipping its horn into a liquid could detect whether or not it contained poison . . .

The close link between the barber and the barber-surgeon from the time of Henry VII onwards provided the barber's pole which is still to be seen in all parts of the world... Tradition says that the patient undergoing blood-letting had to grasp the pole in order to make the blood flow more freely. As the pole was often stained with blood it was painted red. When it was not being used, the barber would suspend it outside the door with the white linen swathing bands twisted around it. Later this custom developed into the practice of having the pole painted red, and white, or black and white, even with red, white and blue or black lines winding round it... Barbers' poles still remain... but the pharmacist and medical practitioner no longer show their ancient signs . . .

— FRANK A. KING
The Canadian Doctor

NURSING SERVICE

Vasculitis of Unknown Origin

WINNIFRED HOOSER

MRS. EASTON WAS BROUGHT to the hospital by ambulance on January 10. Morphine gr. ½ had been given her before she left home because of the intense pain.

On awakening that morning, Mrs. Easton stated that she felt a cramp in the lower part of her right calf and foot. When she put her weight on that foot there was an excruciating pain that started in her heel, shot into her ankle, and up the back of the calf. Within a short time the ankle was sore to touch and rapidly became swollen and discolored. The other ankle soon began to show the same signs. The swelling and discoloration spread up the leg and down the foot. By the time she was admitted to hospital, tender hemorrhagic spots had appeared with two such areas covering two inches in diameter.

A cradle was placed over her legs and a foot board was inserted. The foot of the bed was elevated three notches with shock pins and remained that way for a month. Legs and feet were further elevated using four pillows. Ice bags were applied.

The only immediate history that seemed relevant was the fact that Mrs. Easton had received some x-ray therapy for a lump behind the angle of her right jaw during the previous autumn. This lump had first appeared in 1928 and was thought to be a tuberculous gland. It had become troublesome during the past few months. However, except for a tendency to fatigue and irritability with a weight loss of six pounds, she had been feeling quite well.

The red spots on legs and ankles were very tender. Beneath them were indurated areas of varying size in such a distribution that it suggested they followed the course of the small arteries. Some deep nodules could be felt in the calves. Two pink blotches were noted on the abdomen. All joints were freely movable excepting the ankles which were markedly swollen, hot and painful. A faint dusky purple discoloration extended down the foot.

Sodium salicylate, gr. 15 q.6 h. was started at once. Demerol 100 mgm. and codeine gr. 1 were given alternately q.4 h., with phenobarbital gr. ¼ ordered three times a day after meals. Various blood tests were done.

The second day, Mrs. Easton's wrists began to show signs of edema. They became increasingly painful with the pain radiating up her arms. She complained of a sore throat, had difficulty in swallowing and eventually her breathing became quite labored. Her respirations varied from 20 to 48 a minute. She was placed in an oxygen tent.

By January 13, even though her temperature range was not great — 97° to 120°, her pulse rate was between 120 and 140. In addition to the pronounced edema, there was a constant involuntary twitching and jerking of the muscles. Mrs. Easton became somewhat irrational. The left elbow was aspirated and the fluid sent to the laboratory. No growth or organisms were found. Cortisone was started intramuscularly, 50 mgm. q.4 h., then reduced to q.8 h. the following day. Streptomycin, gm. ½ q.6 h., was given

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for one week, then chloromycetin, drams 2 q.4 h., for two weeks longer.

Several days after admission, Mrs. Easton's lips were swollen, cracked and bleeding, her tongue swollen and her throat very sore. Examination showed that there was a great deal of sloughing of the mucosa of the hard palate. On the soft palate and uvula there was a large, grey, superficial plaque. No edema of the larynx could be visualized so there was no immediate danger of laryngeal closure. Smears taken from the palate and the sloughing area under the tip of the tongue showed a few gram positive cocci and some rare yeast cells. Anesthesin powder was frequently sprayed gently into the throat and mouth for almost a month. These areas were painted twice a day with tincture of gentian violet. Neomycin ointment was applied to the lips frequently with healing effect.

A venous section was done at the left wrist and four blood transfusions were given in one week. The hemoglobin count varied from 78% to 94%. White blood cell counts ranged from 28,225 down to 5,600. Urinalysis showed considerable pus and many yeast cells.

January 16, Mrs. Easton showed a very severe reaction to the cortisone. She became restless, noisy and had hallucinations and ideas of persecution. At this time an in-dwelling catheter was inserted and continuous drainage maintained for one week. Intravenous therapy was started. Invert 10% in water with 1 ampoule of potassium chloride to each 1,500 cc. and 500 cc. of Travert 10% in saline was given during the day. During the night, 1,000 cc. of Travert in water with 500 mgm. Terramycin was alternated with Travert 10% in water.

Constant supervision necessitated three shifts of private nurses every day for several months. Despite constant nursing care the affected areas on the feet and ankles began to break down. The sores were cleansed with denatured alcohol and soft sterile dressings were applied daily. There was a moderate amount of sero-sanguineous discharge from these areas for some time. As healing occurred very heavy scabs formed. Hot lead and opium packs were applied to the arms and legs.

Liquids were forced as much as possible. As soon as Mrs. Easton was able to swallow she was given jelly, custards, junket and pureed baby foods, with milk and eggnogs at half hourly intervals. Nothing hot or even mildly warm could be tolerated by mouth. A light diet was ordered as soon as possible.

Two weeks after admission it was possible to move Mrs. Easton out of the oxygen tent. Several electrocardiographs were made. The first suggested myocardial damage. Later reports indicated that though the rate was rapid the tracings were within normal limits.

From February 22 on, Mrs. Easton was strong enough to be assisted to sit on the side of her bed. She started with five minutes at a time which was gradually increased to 15 minutes. During this time exercises were started for her feet and legs. Though she was able to make her right leg respond, she was unable to move her left leg or foot. When she was well enough to be lifted into a chair the left leg was put into a plaster splint to keep the foot upright. The joints in the right arm and hand were more seriously affected than the left so electric heat was applied for one hour before she exercised her fingers.

Faradic stimulation to the left anterior tibial muscles was started on March 15, and continued until July, with very little response. Physiotherapy with deep heat was applied to both shoulders with good results. Early in May a brace was made to fit a special type of shoe. It was found that by wearing this and advancing through various stages — walker to crutches to cane — she was able to get around with only a little assistance. On orders from the doctor she wore her brace and shoe even in bed.

At the time of her discharge from hospital the final diagnosis was left at acute vasculitis of unknown origin. Mrs. Easton was told to go to the hospital twice weekly to continue with the physiotherapy treatments. There is no indication how long she may have to continue these treatments.

Acute Rheumatic Fever

SISTER MARY EDMUND, O.L.M.

JOAN IS AN EIGHT-YEAR-OLD school girl, a member of a large French-Canadian family. Happy, docile and obedient, Joan, previous to this serious illness, presented the picture of a normal young Canadian girl.

She had been admitted to hospital in January with an acute upper respiratory infection, bilateral sinusitis and possible bronchiectasis. Her sedimentation rate was 73 mm. in one hour. Sedimentation rate is a laboratory test in which a person's blood, prevented from clotting by the use of an anticoagulant, is placed in a graduated glass cylinder and the cells are allowed to settle in the plasma. The significance lies in the rate of speed at which the cells do settle in a given time. Normally, they settle a distance of from one to 20 millimeters in an hour. In infections, however, this rate is greatly increased. So, the doctor knew from Joan's sedimentation rate that her infection was severe. Her pulse rate ranged between 80 and 100 beats per minute, which is normal for a child of this age.

She was on bed rest, and by January 30, her sedimentation rate had dropped to 17 mm. Ambulation was permitted. At the end of a week's time, her sedimentation rate was 27 mm. and her pulse ranged from 100-130 beats per minute.

Joannie was taken home on February 6. The doctor's diary on that date read "probability of rheumatic infection here." Joan's parents were carefully instructed before they left to insist that she obtain extra rest, to lie down for a while in the morning and in the afternoon and to go to bed early at night. A wholesome diet was discussed and they were reminded to return to the doctor in a week or so so that he could check on Joan's improvement.

Sister Mary Edmund is a student in St. Joseph's School of Nursing, Hotel Dieu Hospital, Cornwall, Ontario.

Rheumatic fever is an infectious disease of unknown cause. It occurs in relation to infections with *hemolytic* streptococci. It is thought that rheumatic fever is a hypersensitive reaction of the body tissues to this bacteria or its toxins. It occurs more frequently in the temperate zone, among children in the five to nine age bracket, particularly among children of the lower income class. The fever usually begins acutely following an infection of the upper respiratory tract.

The symptoms of a typical case are: high fever, abdominal pain, polyarthritis, that is, the joints become swollen and inflamed. This inflammation "migrates" — as it subsides in one joint it affects another. The heart rate is rapid, and the signs of carditis may appear in a few days. If the brain is involved the person is said to have chorea. This is manifested by involuntary twitching movements, weakness, and difficulty in performing coordinated actions.

The diagnosis of rheumatic fever is not very difficult when arthritis or chorea occur, but when carditis is the only rheumatic lesion, the condition may escape recognition unless the heart is examined carefully at frequent intervals. Fever, rapid heart rate, and an elevated sedimentation rate are the most dependable evidences of the presence of rheumatic infection.

The prognosis in cases of rheumatic fever involving only the joints is never fatal; chorea is seldom fatal; carditis is the cause of nearly all the deaths. A child rarely dies during a first attack; recurrent attacks lead to death from heart failure, either then or in early adulthood. Patients with moderate heart damage may live to a ripe old age if they lead lives of restricted activity.

On an evening in February, just two weeks after her discharge an acutely ill, very pale, little Joannie was admitted again. She had been having severe coughing and choking

spells, followed by profuse perspiration, with recurrent seizures of vomiting. Her pulse rate was 110 and very irregular. The temperature rectally was 99.6°, which is normal and her respirations were normal, at 20 per minute. Diagnosis: acute rheumatic fever with cardiac involvement.

The doctor's orders, which accompanied Joan, were: 1) remain in bed, 2) light diet, 3) phenobarbital, grains one, at bedtime; 4) urinalysis, 5) C.B.C., differential and sedimentation rate.

Results of blood tests		*Comparison with normal*
Red cell count	4,660,000 per cu. mm.	4,500,000-5,000,000 per cu. mm.
White cells	11,250 per cu. mm.	7,000- 12,000 per cu. mm.
Differential		
lymphocytes	17%	15%
neutrophils	76%	82%
eosinophils	4%	1%
basophils	2%	—
monocytes	1%	2%
Hemoglobin		
	14.8 grams per 100 cc.	15.6 grams per 100 cc.
Sedimentation Rate		
	40 millimeters in 1 hour	0-20 mm. in one hour

Results of Urinalysis	*Comparison with normal*
albumin — positive, 4 plus	negative
acetone — 100 mg. per 100 cc.	none
microscopic examination —	
red blood cells	
pus cells	epithelial cells
casts	crystalline sediment

The blood was essentially normal, with the exception of the increased sedimentation rate. Albumin is often present in the urine in acute infections. It demonstrates some dysfunction of the filtering action of the glomeruli in the kidneys. The presence of acetone indicates acidosis, a condition in which the acid-base balance of the body fluids is disturbed. This electrolyte balance in the body is remarkably constant, in that the tissue fluids and blood are usually maintained at a pH of 7.4, slightly on the alkaline side. Because Joan had been vomiting considerably, the alkali reserve was reduced. Unless this small reduction is corrected, death may result. The doctor had ordered the hypnotic drug to induce sleep by depressing the sensory areas of the cerebral cortex.

Each day Joan became increasingly listless and pale. Her pulse rate averaged 144 per minute; it was full, bounding and irregular. Her respirations increased to 64 a minute and she was perspiring profusely, thus increasing the alkali deficit in her little body.

A carbon dioxide combining power test was ordered. This test is performed on blood serum to determine the degree of acidosis or alkalosis present. The normal value is from 50 to 75 cc. per 100 cc. of blood; this is expressed as volumes per cent. Values below 50 volumes per cent indicate the degree of acidosis; above 75 volumes per cent indicates alkalosis. Joan's CO_2 combining power was 43.9 volumes per cent.

Ringer's lactate was administered intravenously. This is a solution of normal saline containing small quantities of calcium and potassium. It provides the body fluids with the much needed alkaline salts, thus overcoming the alkali deficit.

The doctor also ordered an adrenal hormone preparation 100 mg. stat and q.8 h. The exact action of this drug in the body is not well understood. It affects a return to normal of the temperature, a reduction in the swelling and pain in the joints and produces a sense of general well-being about 24 hours after the initial dose.

S.R. pencillin, 1 cc. daily was or-

dered also. Penicillin is an antibiotic which has a bacteriostatic effect on some of the pathogenic organisms. It was administered mostly as a prophylactic measure during this acute stage when Joan's system was so overwhelmed by the rheumatic infection that she would have no resistance to offer any other infection that might occur.

For a few days Joan appeared to be brighter. She was receiving continuous intravenous administration of 5% glucose in water at 20 drops per minute. The doctor then ordered digitalin, one milligram, q.6 h. This is a drug that acts on the heart muscle, strengthening each contraction but diminishing the number of beats per minute. This was given because Joan's heart was at this time contracting at a rate of 145 times per minute. Nembutal, a sedative, was also ordered to induce relaxation and lessen apprehension.

At this time Joan began to complain of severe pain in her arms and legs when they were moved. She was placed in the orthopneic position to facilitate breathing, which had become increasingly more difficult. Sponge bath were given reasonably often to remove the toxins which were being excreted in the perspiration, also to make Joan more comfortable. We were very careful in moving her arms and legs to cause as little pain as possible. Finally, we placed her in an oxygen tent to help her breathe a little more easily. She was given sips of cool fluids every hour. The fluid intake and output were measured carefully at all times.

On March 1, her pulse rate had increased to 184 beats per minute, respirations were 104, and her temperature rectally was 104.4°. The doctor was notified and he ordered a blood transfusion. After 100 cc. of blood had been absorbed, Joan showed signs of an untoward reaction; she felt chilled and her skin had a dusky pallor. Her temperature rose to 105° rectally, and she was extremely restless. While tossing about in bed, she dislodged the intravenous tubing. Signs of phlebitis appeared around the cut-down area. The leg became swollen and sore to the touch. Dicrysticin was ordered and given intramuscularly to combat the inflammation. Dicrysticin is an antibiotic compound of penicillin and streptomycin, and is used to combat infections caused by mixed organisms. The leg returned to normal several days later.

An electrocardiogram was made. This is a graph picture of the cardiac cycle. Each contraction of the heart muscle gives rise to the flow of electric current. By attaching wires to certain parts of the body, these currents can be intercepted and recorded on a graph thus producing an electrocardiogram. Much can be determined of the condition and rhythm of the heart muscle by a doctor experienced in interpreting this tracing. Joan's graph showed the auricular and ventricular rate to be 138 contractions per minute, with sinus rhythm, which is normal. There was evidence of myocardial damage and hypertrophy, or thickening, of the left ventricular wall.

Joan had considerable abdominal pain at times, which was usually relieved by the application of a hot water bottle.

Two days later Joan was feeling much better. Her temperature dropped to 100°, pulse rate 104, and respirations 18 per minute. As she was breathing more easily, she was taken out of the oxygen tent. The orthopneic position was maintained, however.

She had a persistent cough, which was productive. The sputum was frothy and blood-tinged. During this time, Joan was on a light diet, and she ate fairly well.

At this time, some of the physiological effects of the cortisone appeared: — rounding of the contours of the face and fulness of the buttocks. Psychotic manifestations also appeared — moodiness with mild hallucinations. By a patient and understanding attitude on the part of the nurses looking after her, Joan's distress was somewhat allayed. She was fully cooperative when any procedure to be performed was explained to her first by the nurse.

About two weeks later, symptoms of right ventricular failure appeared, ascites being particularly pronounced. Ascites is a term applied to the presence of free fluid in the peritoneal

cavity. Joan became very restless. Her swollen body was cumbersome and no position we tried seemed to give her much comfort. Her skin was kept clean and fresh by sponging with soap and water. Alcohol rubs and powder were used to keep her back in good condition. This helped a little bit towards easing her restlessness. We were particularly careful to keep the bed dry and smooth at all times. The pillows were frequently rearranged, so that she could relax as much as possible.

Joan was on a low sodium diet now, because sodium causes retention of fluid in the tissues. The intake and output were watched very carefully. We noticed that she was very sensitive to the inquisitive stares of visitors, so we partially screened off her unit, allowing for association with the other little patients, but affording privacy with regard to visitors.

Sadly, this discussion closes with the record of Joan's death. Nursing care played a very important part all through the course of her illness, but unhappily neither it nor the expert medical care were enough.

The study of Joan's care has been of great value to me. I learned the importance of regular medical examination for children, as a prophylactic measure. I understand the utter necessity of following the doctor's orders in returning for a check-up after illness, especially any respiratory infection. I learned, too, the tremendous importance of a properly heated house, nourishing food, and adequate recreational facilities for young children, in the long range prevention of the occurrence of rheumatic fever.

This care study has taught me much that I did not know before about rheumatic fever and its manifestations. It will be invaluable for me in my future interest in public health problems.

With regard to specific nursing procedures, I acquired experience in assisting with the nursing of a patient with an acute fever; one who was temporarily disoriented, and finally one with congestive heart failure. I have had experience with an oxygen tent, continuous intravenous therapy, the administration of several types of drugs, the keeping of an intake and output chart, a special diet, and finally all the ingenious means, that are really learned only through experience, of providing comfort for a restless, breathless patient. This is the challenge — the reliable test of one's nursing ability!

What Rapport Means to Me

A seven-letter word may mean the difference between the nurse's success or failure in her job. That word is rapport. What does it mean, this small word which is so important to nursing? Webster defines it as "an intimate or harmonious relationship as applied to people having a close understanding or working in mutual dependence; the confidence of the subject in the operator with willingness to cooperate." Obviously both of these definitions can be applied to nursing, but how can we bring about this confidence, this relationship which is so necessary? . . .

From the very beginning of her nursing education, the nurse must learn to realize the importance of rapport. Perhaps even before she is taught how to make a bed she should be taught how to make friends. She should be taught to know and appreciate those who are unlike her. And while she is being taught how important nursing knowledge and skills are, she must learn to regard them as the tools of her profession and to use them wisely. Before she learns to give an injection, she must learn to appreciate the fears and anxieties that the patient may feel. Before she can be taught to teach, she must be taught to learn.

With a good background of nursing knowledge and skills, and an understanding of people, the nurse will find that establishing rapport comes easily and naturally; it is part of everyday living.

— GENROSE J. ALFANO
Nursing Outlook, June 1955

Les trois-quarts des ennuis dans la vie des femmes viennent de ce qu'elles se soustraient aux exigences de la discipline, que les hommes acceptent, parce qu'ils en comprennent l'utilité.

— FLORENCE NIGHTINGALE

The Value of Operating Room Experience to the Student Nurse

BETTY ELLISON

FROM MY EXPERIENCE in the operating room I have gained a great deal of knowledge.

First of all, working in the O.R. gives the student the opportunity to apply and augment the knowledge she has gained in other classes. Anatomy is very fundamental and important. I found that I had to brush up on muscles, bones, reproductive systems, especially if I wished to understand what the doctors were talking about. Our previous knowledge of various parts of the body had been acquired through lectures and diagrammatic illustrations. Therefore seeing organs functioning in a human body is an experience in itself. You are able to see that organ in relation to the surrounding tissues and structures.

The application of physiology to the O.R. isn't quite as direct but the relationship is there. The physician's understanding of physiology is necessary in diagnosing the case at hand in order to perform the most beneficial operation. An operation is done to correct an abnormal function. We picked up the physiology more on our own by reading texts and the patient's charts, and asking questions.

Microbiology is stressed. The basic principle upon which the operating room is run is "aseptic technique" — to keep the "microbugs" out. We learned the importance of maintaining the sterility of the equipment used. Many procedures carried out are related to things we learned in our microbiology classes — manipulation of autoclaves, reasons for which they are used, why scrubbing is done and the reasons for draping and skin preparation.

Pharmacology is another subject of importance. We have become familiar with the antiseptics and their uses, and advantages have been learned. In anesthesia, pharmacology comes in again — the drugs used and the factors affecting their use.

Psychology and sociology can be applied in various ways. For example, we learned that we should be kind to the patient by showing interest in him as a person, not as "the gallbladder in C 234"; by not talking about upsetting things like "knives" before the patient is anesthetized, for he will take the anesthetic better if he is relaxed and not disturbed mentally.

Secondly, as a result of my operating room experience, I believe that I will be able to give better nursing care. This is probably the greatest benefit I received, since the ultimate aim of a nurse is to give the best to the patient. Being right there made me realize how important it is for the pre-operative procedures to be done correctly and thoroughly. It causes trouble and elevated tempers if the consent sheet is not signed, or if the name tag is missing. In the future, when I am looking after a post-operative patient, I will know why he is "sore" and has such pains. The leg and breathing exercises will be done thoroughly. I will be able to reassure the operative patient, both pre- and post-operatively, more intelligently and completely, now that I know what surgery entails.

Coming into more intimate contact with the doctors is another benefit reaped from my O.R. experience. Working side by side with a doctor gives a student the feeling that she is really helping and that she may not be the lowest creature in the universe after all. When I watch the doctors operate, I gain more respect for them,

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Miss Ellison is a first year student in the School of Nursing, University of Saskatchewan. Students at this school have a six-week operating term during the first year and have a senior term during the third year preparatory to rural experience.

and realize how little I know.

A great deal of self-improvement can be attained by the student in this department. She must learn to observe, think and act quickly, thoroughly and efficiently. An O.R. nurse must be conscientious and dependable. "Never take a chance even under the most pressing circumstances," is sound logic. Constructive criticism must be taken and benefited from. It is certainly a first-rate way to learn. For example, you don't forget how to put stirrups on if you have been criticized for putting them on wrong. The memory and power of observation must be improved — in learning where the instruments and sterile supplies belong, and being expected to do a procedure after it has been done for you once. Procedures are learned which will be useful in other departments, for example, gowning and gloving for obstetrics. Reading up on the different operations and operative procedures, giving clinics, and generally keeping one's ears and eyes open, results in a larger body of knowledge.

Lastly, a feeling of self-satisfaction comes from being an operating room nurse, even if only for a short time. It makes a person feel good to be able to raise her status from an "in the way" student to "a scrub nurse." It is a wonderful feeling to do a good scrub, that is, to really feel "one" with the surgeon, being able to anticipate his needs and "slap" into his hand what he wants. A goal has been achieved in our being an important part of the O.R. and hospital team which works for the good of the patient.

Yes, I gained a great deal from being in the operating room this last six weeks. I believe that it is an experience of high value to the student, even though it may be rather nerve-wracking at times. It is a good idea to have it early in the student's training rather than only in the third year. I don't feel that I have mastered the procedures as I would have liked to have done, but I will have more incentive to work harder in my third year when I have my second term.

Teamwork

Good teamwork is dependent upon harmonious human relationship. There should be a mutual understanding and appreciation of the capacities of the members of the team. Competition between individuals is detrimental to the effectiveness of teamwork On the other hand, some sound competition between one team and another may sometimes be a useful stimulant.

The team method of work can and should be used at various levels of the nursing service; for example, the head nurses in a hospital or the public health supervisors of a local health unit within a geographical area may constitute a team to study some administrative problem. The nursing personnel of a hospital ward may be organized as a team to plan and give care to the patients of their ward; the public health nursing personnel of a local health unit may function in this way for the improvement of maternal and child care in their district.

When the case work method is being used, the patient may be a member of the team. This occurs most commonly where long-term treatment is necessary, as in a mental hospital or a rehabilitation centre.

The line, lateral and staff relationships exist in the team. The functional relationship may also exist if someone who possesses special knowledge which can contribute towards the solution of a problem temporarily joins the team.

The advantages of the team method of work are mainly to be found in the fact that the team stimulates the initiative and the activity of its members, and that this method lessens the possibility of making mistakes because the problems are attacked from all angles. Also, and this is the main advantage, the team is by definition work-centred.

The team method is more time-consuming until the members have learned to use it. Serious tensions may arise which will cause the collapse of the team if the method is not used with confidence. For these reasons it is essential that all the members receive careful and identical training in the fundamentals, and also that the leader be chosen with the utmost care in regard to skill, knowledge, and ability to work with people.

— Third Report W.H.O. Expert Committee on Nursing

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THE CANADIAN NURSES' ASSOCIATION
UNIVERSITY OF MANITOBA, WINNIPEG
JUNE 25 - 29, 1956

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NURSING EDUCATION

Ce que le médecin attend de l'infirmière professionnelle

GEORGES HÉBERT, M.D.

SANS VOULOIR ENGAGER la responsabilité de mes confrères je puis vous affirmer que le médecin le moins exigeant n'attend de l'infirmière que la perfection. Il ressemble d'ailleurs à bien des maris devant qui les épouses ne trouvent jamais grâce alors qu'eux-mêmes sont si souvent peccables. On peut dire, toutefois, qu'en médecine, le chef autorisé étant nécessairement le médecin, ce dernier se doit — pour le seul bien du malade — de demander à ses collaboratrices, les infirmières, le maximum de leurs qualités, donc, la perfection.

Jamais, en effet, on ne doit perdre de vue le but ultime de l'existence du médecin et des infirmières. Sans le malade, ils n'ont pas raison d'exister. Si le malade est, chacun doit, dès lors, donner toute sa personne pour lui venir en aide. Et, le véritable médecin exige de lui-même ce qu'il attend de ceux qui l'entourent. Il est sévère, il est consciencieux, il est discipliné en même temps qu'il est compatissant, attentif, dévoué, sincère et bon. Il apprend beaucoup de choses et demande que ses principaux collaborateurs s'instruisent également beaucoup. Il se maintient à date dans ses études et désire que ses principaux aides en fassent autant.

Souvent il songe qu'une négligence ne lui est pas permise au détriment de l'être qui souffre, et, il n'admet pas que des fautes de ce genre soient commises par les personnes qui dépendent de lui. Il n'ignore pas qu'il y a encore du mystère en médecine et connaît les limites de la science; par ailleurs, il se sentirait impardonnable de n'avoir pas, par ignorance, prodigué à son malade les traitements récemments découverts. Il sait pardessus tout, et, il pense devant chaque décision de la moindre importance que son premier devoir est d'abord de ne pas nuire (Primum non Nocere) et, il veut protéger son malade de soins intempestifs qui pourraient être administrés par lui-même ou par un aide dont il a la charge. Il est profondément convaincu qu'il ne faut jamais faire à autrui ce qu'on ne voudrait pas qui nous fût fait à nous-mêmes. Et pendant qu'il tâche de soulager un être humain malade, il se dit: voilà le traitement que je désirerais qu'on m'appliquât si j'étais dans la même circonstance. Toutes ces pensées le mûrissent, le rendent conscient de ses véritables responsabilités et en même temps le rendent *exigeant*, parfois même, *intransigeant*. Peut-on l'en blâmer? Qui d'entre nous n'aimerait pas que, dans la maladie, son cas fût traité avec un maximum de sérieux?

Qui n'aimerait pas que sa mère, son père ou son frère ne reçussent les traitements appropriés à leurs douleurs. C'est à l'occasion de la maladie d'un de ses proches que toute personne réalise que ni la médecine, ni l'hôpital, ni les traitements ne doivent être une parodie; il y a des

Dr. Hébert est médecin de l'Hôpital Notre-Dame, Montréal. Conférence donnée à l'amphithéâtre de l'Hôtel-Dieu de Montréal le 9 juin 1955 à l'occasion des journées d'études de l'Association des Hôpitaux catholiques de la Province de Québec.

moments pour badiner et se récréer mais pas en face d'une responsabilité médicale. Pénétré de ces sentiments, le médecin devient exigeant et demande — ce qu'il n'est pas loin d'obtenir — la perfection de l'infirmière: quoi d'étonnant! Pour être parfaite l'infirmière doit posséder des qualités que Dame Nature lui aura prodiguées, des qualités que l'éducation de famille lui aura fournies et des qualités qu'elle aura acquises de l'école d'infirmières où elle aura étudié — inutile de nous attarder sur les talents reçus de la Providence!

Qualités physiques

Comme c'est naturel d'admirer le Beau, le médecin — à l'instar du malade — apprécie chez l'infirmière la beauté, l'élégance et l'intelligence. On ne saurait exiger que toutes nos infirmières soient des Venus. De nos jours toutefois, la jeune fille a de nombreux moyens à sa disposition pour faire ressortir les qualités physiques dont elle est douée, et avec un peu d'attention constante elle parvient assez bien à créer l'illusion de la beauté — si tant est qu'elle n'est pas déjà belle. J'avouerai d'ailleurs que l'amabilité réelle influence beaucoup l'impression qu'on a de ses sembables et on n'est pas loin de les croire beaux s'ils savent manifester une telle qualité. Si la beauté du visage est sympathique celle de la taille l'est également. Aussi le médecin croit-il qu'une infirmière doive surveiller "sa ligne" et montrer ainsi que la santé pour laquelle elle consacre sa vie n'est pas seulement affaire des autres mais aussi la sienne. Insister auprès d'une malade obèse pour qu'elle suive son régime d'amaigrissement est sûrement une tâche plus malaisée pour une infirmière de poids exagéré que pour une autre de poids normal. Pour plusieurs raisons également, il y a avantage à ce que l'infirmière se rapproche de la taille idéale. Celle-ci devra, si possible, s'accompagner d'une démarche élégante. Il arrive trop souvent que soit négligé ce point de vue! Pourtant, un joli port indique parfois une discipline intérieure qu'il est bon de soupçonner chez ces demoiselles à qui l'on confie la grave responsabilité du soin des malades.

Le médecin insiste donc sur les qualités physiques des infirmières: il y voit un point essentiellement réconfortant pour son malade, et il est convaincu qu'en pratique ces qualités existent déjà ou peuvent être obtenues grâce à des soins de beauté recommandables. Dans les rares cas où ces résultats ne pourraient être réalisés, il est à se demander si la jeune fille insuffisamment douée sur ces points ne devrait pas être orientée vers une autre profession. En un temps assez lointain déjà où le recrutement des infirmières ne suscitait aucun problème — alors que je faisais partie du groupe des médecins examinateurs des aspirantes infirmières de l'Hôpital Notre-Dame — nous avions accepté comme règle d'exiger que ces demoiselles aient une stature de cinq pieds minimum et un poids de 100 livres au moins. Nous étions d'avis que le malade hésiterait moins pour demander de l'aide à une jeune fille apparemment capable physiquement de l'accorder qu'à une autre dont la taille serait un handicap. Si la force constabulaire a besoin d'hommes forts et grands, nous croyons qu'un certain barème est également requis pour les infirmières. De nos jours, cette condition n'entre peut-être plus en jeu étant donné que les infirmières sont largement supportées par des gardes-malades et qu'on peut prévoir que dans un avenir assez rapproché leur tâche ne résidera plus qu'à commander à leurs nombreuses aides subalternes!

Toutefois, tant que l'infirmière restera en contact intime avec le malade — ce qui me semble essentiel le médecin croit très recommandable que l'infirmière autant que faire se peut, soit douée de qualités physiques supérieures. S'il le croit ainsi, c'est peut-être d'ailleurs parce que dans le passé et jusqu'à date, il n'a pratiquement jamais constaté de lacune en ce sens. C'est aussi parce qu'il sait qu'aux qualités accordées par la Providence, d'autres peuvent être ajoutées artificiellement avec beaucoup d'art et que dans nombre de cas, l'amabilité et l'intelligence créent l'illusion de la beauté. Il n'est pas assez d'être jolie pour une infirmière; elle doit avoir en

plus une bonne éducation de famille. Voilà un point qui évidemment dépasse en importance la question des qualités physiques.

Education de famille

L'éducation de famille donne un ensemble de qualités subtiles qui rendent les contacts humains plus humains si l'on peut dire! Elle les ennoblit, les enrichit de bonté, de douceur, de compréhension, de pénétration, de télépathie et je dirais presque d'amour. L'être humain qui a reçu une bonne éducation de famille est un être raffiné. Il pense aux autres plus qu'à lui-même, il est capable de sacrifices et de dévouement. C'est celui à qui sa mère a mille fois répété dans son enfance: ne pense pas toujours à toi-même, ne te choque pas au jeu; donne raison à ton ami, ne bouscule pas celui-ci, ne garde pas rancune à celui-là, partage ton avoir avec un autre moins fortuné que toi: tiens-toi droit à table, ne sape pas en mangeant; mets ton gilet avant d'entrer au salon, lave tes mains avant de faire tes devoirs; sois toujours propre à l'école, ne réponds pas à ton professeur de classe; ne t'entête pas a discuter, encore moins avec tes supérieurs, ne critique pas l'autorité, cède ta place à une dame ou à un veillard dans un tramway ou dans un autobus, n'oublie pas ta prière; et quand, plus vieux, il part en voyage, elle lui redit avec son regard maternel: conduis-toi bien. Ces recommandations d'une mère à son fils ou à sa fille sont imprégnées de patience et de fermeté. A la longue, l'enfant sans le réaliser, a acquis ce que rien d'autre au monde ne pourra jamais lui offrir: la véritable éducation. On la reconnait à première vue par la maintien, le démarche, le respect d'autrui, la courtoisie, l'amabilité, le dévouement. Ce sont justement là les qualités qu'on demande à une infirmière. Il faut en effet qu'elle sache d'abord se présenter auprès du malade. C'est chose simple pour celle qui, dans sa famille, a toujours été soumise à une discipline de bonne éducation. Est-ce plus difficile de se présenter à un malade dont on aura la charge que de recontrer quelqu'un chez soi? Si l'infirmière a, dès son bas âge, appris à être polie pour l'invité qu'elle recevait ou pour l'hôte à qui l'on rendait visite, elle sera également à l'aise avec son malade et sans la moindre difficulté. Elle saura qu'elle peut être parfaitement aimable sans être familière; elle saura facilement se protéger sans esclandre d'un malotru dont les propos sont déplacés, d'ailleurs, elle ne sera pas souvent en butte à ces ennuis grâce au respect qu'elle aura su inspirer même à des personnes d'une éducation douteuse. Elle ne sera pas de celles qui ont toujours l'impression d'avoir à se défendre contre le sexe masculin que — subconsciemment ou non — elles ont légèrement provoqué!

Si l'éducation de l'infirmière est parfaite, elle saura dire et faire ce qui doit être fait, qu'il s'agisse du malade riche ou du pauvre. Elle saura que le raffinement réel n'est pas l'apanage des grandes fortunes; qu'au contraire on peut le découvrir sous l'habit le plus simple. D'ailleurs si la jeunesse de l'infirmière l'a empêchée de comprendre ce point avant ses études à l'hôpital, les différents stages de son cours l'auront vite convaincue! L'éducation de famille en plus de donner à l'individu l'art de se présenter lui donne de l'aisance également dans nombre de circonstances de la vie. Habituée chez elle à une tenue impeccable, l'infirmière la conserve pendant son cours et, après bien entendu!

Doit-elle faire son service à domicile, elle est parfaitement à son aise chez les plus grands seigneurs et sa tenue leur inspire confiance; doit-elle habiter sous un toit plus humble, elle sert d'exemple, et, de nouveau, elle inspire confiance au malade en même temps qu'elle maintient à son niveau le standard de la profession d'infirmière. Instinctivement, elle suit les recommandations de sa mère autrefois et pratique les règles élémentaires d'hygiène: on n'imagine pas, en effet, une infirmière oubliant le simple lavage des mains aussi souvent que nécessaire et tout particulièrement avant de manger. Il vaut mieux en ce sens pécher par excès que par omission! Le malade, les parents de ce dernier et même le médecin, ont toujours l'oeil sur la propreté de l'infirmière.

Nul être ne saurait concevoir la malpropreté chez celle qui prend si intimement soin de lui. La question de la propreté est un problème capital et on ne saurait être surpris si le médecin insiste sur la nécessité de cette qualité essentielle chez sa collaboratrice. En plus d'une hygiène impeccable, l'éducation de famille aura enseigné à l'infirmière l'art de la table. Elle est en effet parfaite dans son maintien, n'hésite pas devant les ustensiles à utiliser si le repas est un peu élaboré, et de plus, elle sait cuire à l'occasion un petit steak aux champignons, un filet de doré amandine, et que sais-je encore? Même si elle n'est pas diététiste elle connaît la composition d'un repas bien équilibré et ne conçoit pas un dîner où la soupe aux pois précède les fèves au lard et celles-ci suivies d'un tarte quelconque.

L'infirmière bien élevée a l'air et est distinguée. Sa tenue est toujours irréprochable, sa coiffure de bon goût et son uniforme immaculé. En présence de son malade elle l'écoute patiemment et le réconforte avec psychologie. De nature délicate, elle sait ce qu'il faut dire et surtout ce qu'il ne faut pas dire. Ce n'est pas elle qui, parlant d'une dame âgée l'appelle la "petite mère": causant avec une femme de 60 ans elle n'affirme pas que Madame une telle est une vieille femme, qu'elle a bien 50 ans, elle n'ajoutera pas non plus: vous êtes bien moins vieille que Madame X. Toujours elle se souvient que sa mère lui répétait combien il est odieux de soulever la question des âges dans la conversation et d'en établir des comparaisons. Dans un même ordre d'idées l'infirmière bien élevée est discrète.

Discrétion

Ici, je suis obligé d'ouvrir une parenthèse et dire avec regret que nos infirmières, surtout les infirmières licenciées, faisant, ce que l'on est convenu d'appeler, du service privé — méritent très souvent des reproches ce sont de véritables commères qui racontent à leur dernier malade tout ce qu'elles savent sur chacun des malades antérieurs auprès desquels elles ont été appelées. C'est là une disgrâce contre laquelle je ne saurais assez m'élever et qui atteint souvent des infirmières habiles par ailleurs. Peut-on imaginer qu'étant sous secret professionnel l'infirmière raconte ce qu'elle a vu chez Monsieur X qu'elle propage le diagnostic de telle maladie que lui-même cherche à cacher à ses plus intimes et qu'elle sourit même en colportant ses infirmités. Peut-on croire qu'une infirmière aille dire à tout venant comment Madame X fait excès de boisson ou est une habituée des narcotiques. Peut-on croire qu'une infirmière dont le rôle est sacré, cherche à soutenir l'intérêt d'une conversation dans un salon, un restaurant ou ailleurs en mettant au jour une série de faiblesses humaines dont elle a été mise au courant par sa seule profession. Bien plus, pour donner plus de vivacité à ses affirmations elle ajoute stupidement et fièrement: "Ce que je dis, je le sais. J'ai été en service privé auprès de cette personne pendant six mois: toute la famille je la connais! A part ça, le premier docteur qui l'avait traité s'était mis les pieds dans les plats. Heureusement que j'ai averti la famille de prendre un autre docteur!" Voilà des histoires scandaleuses qui malheureusement surviennent trop souvent; elles sont le fait d'une mauvaise éducation de famille et même si les écoles d'infirmières insistent continuellement sur cette question de discrétion, je crains qu'il n'y ait encore de ces fautes impardonnables. Peut-être l'infirmière observant le médecin pourrait-elle parfois lui faire un reproche semblable. Soyez sûres qu'il est encore moins excusable et que la cause réside toujours dans une insuffisance d'éducation de famille. Fermons cette pénible parenthèse ouverte dans l'espoir de faire réfléchir celle qui aurait pu oublier l'enseignement reçu dans son enfance ou dans son école et à qui vous communiqueriez mon indignation devant l'indiscrétion de l'infirmière, devant le viol de son secret professionnel.

(La suite au prochain numéro.)

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Full-time Work, Part-time School

GENEVA LEWIS

THERE WAS A TIME, not too many years ago, when the nurse who graduated from the regular three-year course of training was considered fully prepared for any and every demand made upon her professional skills. If she engaged in private nursing, as the great majority of new graduates did in that day, she was adept at transferring the techniques she had learned through ward practice to the individual patient entrusted to her care. When bedside nursing was extended to patients in their own homes, a few new skills were needed but essentially the nurse was prepared to give all of the care required without running into too many questions she could not answer.

The opening of the new era when nurses were responsible for the preservation of health rather than limiting their work to curative care, led to the development of basic courses in public health nursing under the sponsorship of university schools of nursing. For many years now the average public health nurse has had at least one year of university education as a supplement to her training in a hospital school. Some few have had more.

One year of basic instruction in the classroom, combined with one month of field work, cannot qualify a nurse to serve a demanding public adequately; nor is it intended to. All that can be presented in that year is a general knowledge of basic principles which the nurse must learn to apply to the specific problems in a real situation. This is experience. The conscientious nurse realizes her own shortcomings and knows that much of the help that she should be giving is beyond her limited scope of knowledge. She tries to supplement her background by reading. Acceptance of ready-made ideas is not enough. She needs the stimulation of discussion and presentation of other viewpoints to bring the new ideas into proper focus.

The changing concept of nursing demands that nurses take their place as full-pledged members of an important profession. Not only must we be prepared to meet this challenge, but facilities for the continuing professional education of nurses should be readily available. The obvious answer to this problem is "back-to-school," but for one reason or another, few of us are in the position, financially or otherwise, to leave our homes and work for an indefinite period to further our education. The only solution seems to be a system of education which would enable us to remain at home, continue working and attend classes in off-duy time. Evening and Saturday classes have been instituted for other professions: why not for nursing?

There does not seem to be a shortage of qualified teachers — only limited use of those available. It is more economical to use the same facilities to teach fifty students than to teach ten. Within a radius of 50 miles of each university centre, there are large numbers of nurses who could and, undoubtedly, would take advantage of evening classes as a means of furthering their education for their own satisfaction or for preparation for advanced positions, if such classes were organized and advertised.

It was for this reason that late afternoon and evening classes were instituted in the school of nursing at the University of Buffalo. Because I wanted more knowledge, a broader understanding, I enrolled there.

Can a nurse work during the day and attend classes at night without adding stress to a demanding position? Yes, I believe she can. The fatigue felt after a full day's work is more often than not the product of incipient boredom. We all get "stale." The benefits she derives from her educational program more than compensate the nurse for any physical strain. The stimulation of new ideas and new

Miss Lewis is supervisor, Public Health Nursing, Welland and District Health Unit in Ontario.

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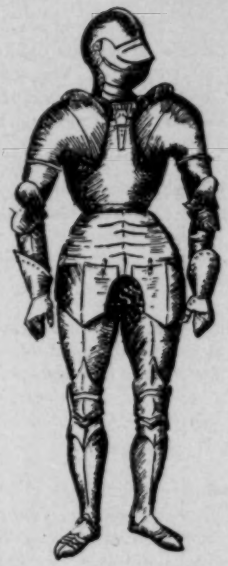

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methods makes her a more satisfactory worker. Directed study is a steady stimulus to better and more effective work.

It takes a little effort and a little "stick-to-it-iveness," but it is well worth while. I am now starting my fourth year and have enjoyed every minute of it. I heartily recommend it to every public health nurse.

In Memoriam

Jessie K. (Smith) Agnew, a graduate of Victoria Hospital, London, Ont., died at Crestline, Ohio, on July 19, 1955.

* * *

Ada Ruth (Walker) Anderson, who graduated from the General Hospital, Hamilton, Ont., in 1910 died at Victoria, B.C. on July 30, 1955, at the age of 72. Mrs. Anderson served overseas with the C.A.M.C. during World War 1.

* * *

Katherine Ella Brownlow, who had nursed at Victoria, B.C., died suddenly on July 29, 1955, at the age of 63.

* * *

Ruth Annie (Jeffs) Evans, who graduated from Women's College Hospital, Toronto, in 1932, died at Toronto on June 13, 1955.

* * *

Florence E. Gordon, a graduate of the Montreal General Hospital died on July 26, 1955, after a short illness. Miss Gordon had held responsible positions with the Western Division of M.G.H., the Military Hospital at Ste. Anne de Bellevue, Saguenay General Hospital, Arvida, and Verdun Protestant Hospital.

* * *

Lucy A. (Hunter) Gordon, a graduate of Newton (Mass.) Cottage Hospital in 1894 died at Alberton, P.E.I., on July 24, 1955, at the age of 88. Engaged in private nursing prior to her marriage in 1906, Mrs. Gordon had operated a small private nursing home in Alberton for a time.

* * *

Helen M. Hamer, who graduated from St. Michael's Hospital, Toronto, in 1906, died at Port Arthur, Ont., on August 24, 1955. Miss Hamer retired from active nursing eighteen years ago.

* * *

Jane Parnell who trained in Victoria and who worked at New Westminster, B.C., died at Vernon, B.C. on July 12, 1955.

* * *

Sophia Alice Watkins, who graduated from the Royal Victoria Hospital, Montreal, in 1910, died at Toronto in August, 1955, at the age of 70. Miss Watkins served with the C.A.M.C. in England, France and Egypt during World War 1.

* * *

Florence Waugh, who graduated from Victoria Hospital, London, Ont., and in public health nursing from the University of Western Ontario, died at London on August 1, 1955.

* * *

Clara Mildred White, who graduated from the Royal Victoria Hospital, Montreal, in 1903, died at Ottawa on August 4, 1955, at the age of 83. For many years Miss White was assistant superintendent of nurses at R.V.H.

* * *

Mary Wilson, a graduate of St. Thomas's Hospital, London, Eng. died at Victoria on July 18, 1955, at the age of 85. Miss Wilson had practised her profession in Calgary, Regina and Victoria.

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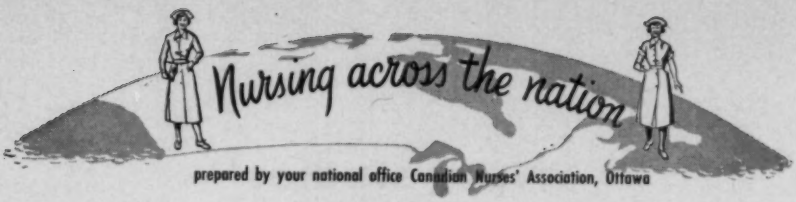

Educational Opportunities in Canada

The major objective of this column is to keep its readers posted on new developments in nursing across Canada. University schools of nursing have, by continuous study of the educational needs of nurses, assisted greatly in much of the progress we have made to date. Commencing in 1919 Canadian Universities have prepared nurses for positions in public health, teaching, supervision, administration and some of the clinical specialties. However, it has been necessary heretofore for nurses wishing to obtain special preparation for teaching the sciences in schools of nursing to attend universities in the United States.

This year the School of Nursing at McMaster University in Hamilton, Ontario, is offering a two-year degree course for registered nurses especially designed to prepare science teachers for schools of nursing. The program is broad and varied and includes studies in the humanities, the social, biological and physical sciences, nursing education and pedagogy. The degree Bachelor of Nursing Education is awarded after two academic years of study and when the full requirements of the course have been met.

Kitchener-Waterloo Rotary Scholarship

During the past few months National Office has had the opportunity of assisting the International Service Committee of the Kitchener-Waterloo Rotary Club in what is, for them, a new project, for their Golden Anniversary Year. Several months ago Mr. C. A. Pollock, chairman of the Committee, requested our advice regarding arrangements that might be made to bring a nurse from a British Commonwealth country where nursing is not highly developed, to Canada for a year of study. Through the International Council of Nurses and the British Colonial Office, we obtained information about several Commonwealth countries where assistance in the form of a scholarship to a nurse would be appreciated. Finally, Miss **Joyce Owen,** a ward sister at the Public Hospital, Georgetown, British Guiana, was selected and will be coming to Canada in the near future. Upon the request of the Director of Medical Services of British Guiana, a program in psychiatric nursing is being arranged for her as well as an orientation to Canadian life and nursing in Kitchener.

We are most grateful to the Kitchener-Waterloo Rotary Club for its interest in nursing and for requesting the C.N.A. to assist in choosing the recipient of the scholarship and planning her program.

Films and Filmstrips

The following films have been recently evaluated by a film panel consisting of representatives from the Department of National Health & Welfare and the Canadian Nurses' Association and have been recommended for inclusion in the National Health Film Library:

Someone Who Cares (1953) 16 mm., black and white — 22 minutes.

Beginning with scenes typifying the hustle and bustle of daily life the film points out the extent of mental illness in North America today and explains that people from all walks of life may become victims of some kind of emotional or mental disorder. It shows some of the conditions that exist in mental hospitals and describes the need of mental hospital volunteers who

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will help alleviate the loneliness that exists and give patients a link with the outside world. In particular it shows the type of work done by volunteers, emphasizing the fact that volunteers come from every walk of life.

Throughout the film the great need today for mental hospital volunteers is stressed. The fact that no special qualifications are needed except the desire to contribute to the inhabitants of these hospitals is well portrayed. This film could be used to good advantage with community groups and service clubs in an endeavor to interest them in this necessary and worthwhile work.

Troubled Mind (1954) 16 mm., black and white, 21½ minutes.

Made primarily to interest women in training as mental hospital nurses this British-made film also shows conditions and treatment of patients in a large British mental hospital. It shows a girl entering mental health nursing for the first time. She writes home to tell how she is getting on and we follow her through the various phases of her training.

This is an excellent film which could be used to advantage in schools of nursing, preparatory to the students' experience in psychiatric nursing. It would do much to dispel erroneous notions about mental hospitals, and may encourage nurses to enter this field of nursing.

Disinfection of Clinical Thermometers (1952), 67 frames, color — purchase price approximately $9.10.

This seven-minute filmstrip demonstrates procedure to be followed in the disinfection of clinical thermometers. Made by the U.S. Public Health Service it outlines in a clear, easy-to-follow manner, all the steps taken in the disinfection process.

It should prove useful to those planning a revision of their technique, for an in-service program and for teaching both students and auxiliary nursing personnel. It is an excellent teaching aid.

A disc which accompanies the filmstrip gives the commentary on the procedure to be used but could be ignored in favor of a script which an instructor would use as necessary.

These films are all available from the National Health Film Library on application to the Canadian Film Institute, 148 Sparks St., Ottawa. A small charge is made for rental and borrowers should make their requests for films as far as possible in advance, indicating the proposed date of showing.

Visitor to National Office

We welcomed to National Office recently, Miss Eleanor Graham who, for the past two years, has been attached to the Regional Office of WHO in New Delhi. Miss Graham, previously director of nursing at the Royal Columbian Hospital, New Westminster, B.C., had been enjoying a vacation in Canada and was winding up her travels as she prepared to return to her overseas post. How interesting to hear of the work being carried on by our Canadian nurses and of the fine impressions they have made on the native populations of the countries in which they serve.

Advice to Youth

Do not stop to think about the reasons for what you are doing, about why you are questioning. The important thing is not to stop questioning. Curiosity has its own reason for existence. One cannot but help but be in awe when he contemplates the mysteries of eternity, of life, of the marvellous structure of reality.

It is enough if one tries merely to comprehend a little of this mystery each day. Never lose a holy curiosity. Try not to become a man of success but rather try to become a man of value. He is considered successful in our day who gets more out of life than he puts in. But a man of value will give more than he receives.

— Albert Einstein

* * *

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Le Nursing à travers le pays

Avantages de l'Education au Canada

Le but principal de cette colonne est de tenir nos lecteurs au courant des développements qui surviennent dans la profession du nursing, à travers le pays. Les écoles universitaires de nursing, par leur étude constante des besoins des infirmières en matière d'éducation, ont largement contribué aux progrès réalisés jusqu'à présent dans la profession d'infirmière. Depuis 1919, nos universités canadiennes préparent des infirmières pour le service d'hygiène publique, l'enseignement, la surveillance, l'administration et certaines spécialités cliniques.

Autrefois, les infirmières qui désiraient se spécialiser pour l'enseignement des sciences, devaient aller chercher cette instruction aux Etats-Unis.

Cette année, l'Ecole d'infirmières de l'Université McMaster à Hamilton, Ontario, met à la disposition des infirmières enregistrées un cours de deux années pour celles qui désirent se qualifier pour l'enseignement des sciences dans les écoles d'infirmières. Le programme est vaste et varié comprenant les lettres, les sciences sociales, la biologie, la physique, l'enseignement en nursing et la pédagogie. Le Baccalauréat en Enseignement du Nursing est accordé au terme des deux années de cours aux candidates répondant aux conditions exigées.

Bourse d'Etudes offerte par le Club Kitchener-Waterloo Rotary

Notre Bureau national a eu l'avantage, au cours des derniers mois, de contribuer à une initiative du Comité du Service International du Club Kitchener-Waterloo Rotary, à l'occasion de son Jubilé d'Or. Il y a déjà quelques mois, le président du Comité, M. C. A. Pollock, nous demanda notre avis concernant le projet d'amener au Canada, pour une année d'études, une infirmière d'un des pays du Commonwealth où la profession d'infirmière n'est pas aussi avancée que chez-nous. Par l'entremise du Conseil International des Infirmières et du British Colonial Office, nous nous sommes renseignées sur plusieurs de ces pays qui pourraient bénéficier d'une assistance sous la forme d'une bourse d'études accordée à une de leurs infirmières. En définitive, le choix tomba sur Mlle Joyce Owen, infirmière du Public Hospital, Georgetown, Guyane Anglaise, qui arrivera prochainement au Canada. A la demande du Directeur des Services médicaux de la Guyane Anglaise, un programme de soins en psychiatrie sera tracé à l'intention de cette infirmière de même qu'un plan d'orientation à la vie canadienne et à la profession d'infirmière à Kitchener.

Nous désirons exprimer notre reconnaissance au Club Kitchener-Waterloo Rotary pour l'intérêt ainsi démontré à la cause du nursing ainsi que d'avoir bien voulu prier l'Association des Infirmières Canadiennes de les diriger dans le choix d'une boursière et l'organisation d'un programme d'expérience en sa faveur.

Films et Bandes fixes

Les films suivants ont récemment été évalués par un comité composé de représentants du Ministère de la Santé Nationale et du Bien-Etre et de l'Association des Infirmières Canadiennes et ont été recommandés pour la cinémathèque du Ministère de la Santé Nationale.

Some one Who Cares (1953) 16 mm., en noir et blanc — 22 minutes.

Débutant par des scènes symbolisant la vie trépidante de chaque jour, le film fait ressortir la fréquence des maladies mentales, aujourd'hui, sur le continent nord américain et démontre que, dans toutes les classes de la société, des gens peuvent être victimes de troubles émotifs ou mentaux sous quelque forme. Il montre aussi comment cela se passe dans les hôpitaux pour maladies mentales et illustre bien le besoin, dans ces institutions, de l'assistance de personnes dévouées qui viendraient, volontairement, distraire les malades dans leur solitude et être en quelque sorte pour eux, un lien avec le monde extérieur. Le film montre en particulier l'oeuvre humanitaire accomplie par ces volontaires qui viennent de tous les degrés de l'échelle sociale.

Tout le long du film, on insiste sur le grand besoin de ces bénévoles, appuyant sur le fait que la seule qualité requise de ces

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obligeantes personnes est le désir de rendre service. Ce film pourrait être avantageusement utilisé dans les réunions paroissiales, cercles, clubs, etc. afin d'intéresser ces groupes à cette œuvre si nécessaire et si utile.

Troubled Mind (1954) 16 mm., en blanc et noir, 21½ minutes.

Conçu essentiellement pour susciter chez les jeunes filles l'intérêt dans la profession d'infirmière, pour le soin des malades mentaux, ce film, fait en Angleterre, montre aussi la vie et le traitement des malades dans un grand hôpital britannique pour maladies mentales. Il nous fait voir une jeune fille à ses débuts dans le soin des malades mentaux; elle écrit à sa famille pour donner de ses nouvelles et nous la suivons ainsi à travers les différentes phases de sa formation.

C'est un excellent film que l'on aura tout avantage à montrer dans les écoles d'infirmières pour préparer les étudiantes à leur stage en psychiatrie. Il contribuera aussi à dissiper les idées fausses que l'on se fait souvent au sujet des hôpitaux pour malades mentaux et encouragera peut-être des infirmières à se diriger vers ce domaine de la profession.

Désinfection des thermomètres médicaux. (1952) 67 images, en couleur; prix d'achat, environ $2.50.

Ce court métrage de sept minutes démontre la technique à suivre dans la désinfection des thermomètres. Monté par le Service d'Hygiène Publique des Etats-Unis, il démontre d'une façon claire et facile à suivre toutes les opérations de la désinfection.

Il sera très utile lorsque l'on voudra faire une revue de la technique ainsi que dans un programme de formation en cours d'emploi ou pour l'enseignement aux étudiantes de même qu'au personnel d'auxiliaires en nursing. C'est un excellent complément à l'enseignement.

Un disque, accompagnant ce film, donne les instructions sur les procédés à suivre mais peut être remplacé par un texte que l'institutrice peut utiliser à sa guise.

Ces films peuvent être obtenus à la Cinémathèque de la Santé Nationale en s'adressant à l'Institut Canadien du Film, 148 rue Sparks, Ottawa, Ont. Une faible rétribution est exigée pour la location des films et on est prié de les retenir aussi à l'avance que possible, en indiquant la date à laquelle on désire s'en servir.

Visiteur au Bureau National

Nous avons eu le laisir de recevoir à notre bureau la visite de Mlle Eleanor Graham, attachée depuis deux ans au Bureau régional de l'Organisation Mondiale de la Santé à la Nouvelle Delhi. Mlle Graham, précédemment directrice du nursing au Royal Columbian Hospital, New Westminster, B.C., retournait prendre son poste outre-mer, après une vacance au Canada. Qu'il est intéressant d'entendre parler du travail accompli par nos infirmières canadiennes et de l'excellente impression qu'elles ont fait sur les indigènes des pays dans lesquels elles sont appelées à servir.

Thoughts on Education

Among the speakers at the fifth National Seminar organized by the Indian Adult Education Association was His Highness Maharaja Sir Jayachamaraja Wadiyar Bahadur of Mysore. He had this to say:

"The enlargement of the mind through knowledge is only one of the aims of the education of the adult, as indeed of all education. Of at least equal importance is the enrichment of other parts of the personality of the learners — the encouragement of their group consciousness and social virtues, the stimulation and satisfaction of their esthetic needs, and the elevation of their hearts and souls.

"Education is after all only a means to an end, the end, namely, of making men and women fit for an intelligent, cultured and fruitful life. The success of any system of education, as well as the desirability of its aims, methods and techniques, can be judged only by the quality of the citizens whom it helps to produce and train.

"As education is an enterprise of nation-building, it is imperative to attach equal importance to all its levels and branches. The education of the adult demands the same care, thoroughness and imagination in planning and execution as the education of the young.

"It is equally necessary not only to instil a passion for truth and justice, but also to inculcate a love for order and beauty. A cultural renaissance affords the best foundation and offers the best guarantee for the educational progress of the nation."

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Sélection

L'infirmière travaillant seule en colonies*

L'auteur nous fait part de ses réflexions non seulement sur le travail de l'infirmière en colonies, mais sur ce qui peut affecter la population: mouvement des infirmières vers de plus grands centres, pratique de la médecine, etc.

L'infirmière, dit-elle, en acceptant un emploi dans des centres reculés, est animée de l'esprit d'aventure et de dévouement qui a caractérisé, dans le passé, les pionniers de notre pays. La majorité d'entre elles acceptent le manque de confort: voyages par tous les temps et travail dans des conditions peu favorables de certains foyers. Il est vrai que maintenant, il est souvent possible à l'infirmière de réintégrer, chaque soir, un domicile confortable.

La loyauté de l'infirmière dans son travail est exemplaire. Elle constate la grande contribution qu'elle peut apporter à l'amélioration de la santé publique: elle ira même jusqu'à prolonger ses heures de travail aux dépens de ses loisirs; elle devra toutefois se rappeler que "trop de travail et pas assez de distraction peut nuire autant à son travail qu'à elle-même." La ligne de conduite adoptée par certains services de santé consiste à rappeler les infirmières, travaillant seules, tous les deux ans afin de les faire travailler pendant six mois avec d'autres infirmières et un personnel médical, les empêchant ainsi de sombrer dans la routine et les obligeant à s'intéresser à autre chose qu'à leur travail.

Une analyse des soins à donner à la population d'une colonie révèle que les principes du nursing dans les colonies sont identiques à ceux auxquels nous sommes habitués et qui sont acceptés partout. Le médecin demeure le capitaine de l'équipe. C'est sous sa direction que le malade est traité, même s'il est rarement présent au moment de l'administration des traitements. Il faut que l'infirmière qui travaille seule soit en garde, en donnant des soins aux habitants de la colonie, contre tout ce qui n'est pas exclusivement de son domaine, tel que diagnostiquer, prescrire, traiter ou opérer. La prudence et la justice l'obligent à se poser cette question: Ce que je fais serait-il légal sous la surveillance *directe* d'un médecin? Dans l'affirmative, la mesure est du domaine de l'infirmière; dans la négative, quoiqu'elle soit obligée, à cause de l'absence du médecin, d'exercer la médecine, elle doit redoubler de prudence en prenant les mesures nécessaires, en cas d'urgence, jusqu'à ce qu'un rapport puisse être fait au médecin dont elle relève et qu'elle en ait reçu les directives.

L'établissement du diagnostic par l'infirmière n'est pas toujours nécessaire; il n'en reste pas moins qu'une observation intelligente et un rapport fidèle des signes et de certains symptômes relèvent de l'infirmière, quel que soit l'endroit où elle exerce ses fonctions.

Pourquoi les infirmières acceptent-elles de travailler en colonie plutôt que dans les régions rurales et dans les petits centres urbains?

L'auteur croit qu'il est regrettable mais compréhensible, dans un temps où les facilités de travail abondent, que les infirmières se dirigent là où l'éducation et l'entraînement atteignent un degré que la plupart d'entre elles désiraient depuis longtemps. Dans les régions rurales et les petits centres, les avantages offerts par les grandes villes manquent et l'infirmière n'y peut acquérir l'expérience et la satisfaction de celle qui travaille seule dans une colonie.

Cette question du personnel pour les hôpitaux des petits centres et des régions rurales semble avoir préoccupé l'auteur et voici quelques-unes de ses réflexions: La meilleure politique pour embaucher un personnel qualifié est d'offrir une échelle de salaire raisonnable, des vacances annuelles et un congé suffisant en maladie; en plus, l'occasion de se livrer à des études approfondies, une compensation pour le travail supplémentaire et, enfin, un bon plan de pension de retraite.

Ayant réussi à attirer les infirmières, la façon de les *retenir* est de s'assurer les services d'un personnel administratif hautement qualifié.

Les règlements concernant le personnel peuvent paraître excellents en théorie mais sans le secours d'administrateurs-médecins,

---

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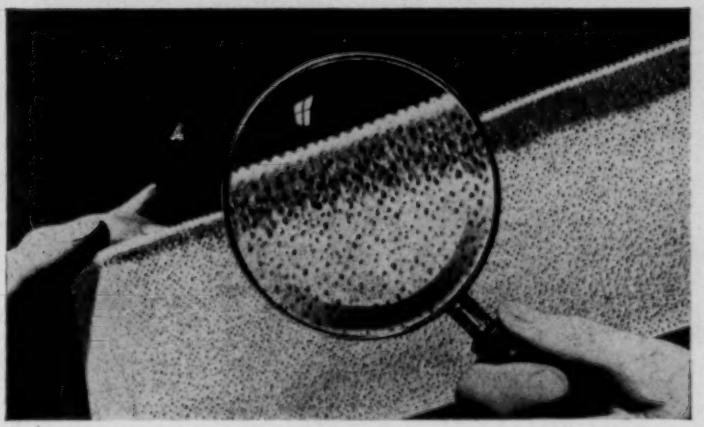

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infirmières, hommes d'affaires avertis — qui ont eu l'avantage d'acquérir une réelle compréhension de leurs semblables et qui sont disposés à mettre de côté leurs vues personnelles pour le bien commun de la société, les départs parmi le personnel demeureront élevés.

L'auteur cite d'un article de *l'American Journal of Nursing*, les lignes suivantes: "Lorsque tous les membres d'un personnel travaillent en collaboration plutôt que sous la domination les uns des autres; lorsque les problèmes sont étudiés en commun, chacun s'efforçant de comprendre le point de vue de l'autre ainsi que ses réactions, un grand pas est alors fait dans l'amélioration des relations humaines." Les difficultés à retenir le personnel seraient moindres si cette idée était mise en pratique.

En terminant, l'auteur insiste sur le choix judicieux du personnel des colonies. Seules les infirmières ayant fait preuve d'un jugement sûr et d'un esprit mûri devraient accomplir ce travail.

Résumé d'un article de Mlle Alice Smith. *L'Infirmière canadienne* décembre, 1954. Extrait d'une traduction de Mlle G. Parent, étudiante à l'Ecole d'Hygiène de l'Université de Montréal.

Tout homme reçoit deux sortes d'éducation: L'une qui lui est donnée par ses semblables, et l'autre beaucoup plus importante, qu'il se donne lui-même.

— Cardinal Gibbons

* * *

Les enfants ont des joies immodérées et des afflictions amères sur de très petits sujets.

— La Bruyère

Il faut considérer l'humanité comme un homme qui vieillit continuellement et qui apprend toujours. — Blaise Pascal

* * *

Gagner sa vie, quelle excellente hygiène!

— Francois Coppée

* * *

Le tennis et le golf peuvent développer les muscles d'une femme, mais un balai ferait la même chose. — Paul Tyndall

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Book Reviews

Progress and Problems in Mental Hospitals (proceedings of the 5th Mental Hospital Institute, held under the auspices of the American Psychiatric Association, Mental Hospital Service). Prepared for publication by Daniel Blain, M.D., Medical Director, A P A., Editor and Stella B. Hanau, Consultant Editor. 204 pages. Price $2.50.

Reviewed by Mary E. Colledge, Director of Nursing, Verdun Protestant Hospital, Verdun, P.Q.

There are twelve sections in this book, some of which will be of interest to all and some only to a few. Sections 3, 4, 5, 6, 7, 11 and 12 deal with follow-up studies of mental patients, law, therapies, training and research, clothing and laundry, equipment and geriatric architecture. In each of these there are things that pertain to all of us. For instance, although the section on law applies particularly to the U.S., it would stimulate most of us to think about our own laws with regard to the status of ourselves and our patients. The discussion on geriatric architecture brings home to us again the problem of our older age groups and what is being done to alleviate some of their problems.

The opening address of the President of the American Psychiatric Association, Dr. K. Appel, on "Public Support" was of particular interest. He gives reasons for not having public support and ways of obtaining this when necessary. He advocates "psychiatric training for all medical students plus interneship in psychiatry." This of course is being done in some progressive general hospitals in Canada. Actually nursing is far ahead by making psychiatric affiliation compulsory in our training schools. While 50% of all hospital beds are filled with psychiatric patients, it is indeed a disgrace that a great number of our medically-trained people have had no training in psychiatry.

By its title, Part 1 of Section 2, dealing with administration practices gives good commonsense advice. Administration is everybody's job, and any number of hospital personnel would profit from reading it. Part 2, "The Right People in the Right Places" can apply to any hospital. Since psychiatry has paid particular attention to interpersonal relationships, the answers some of the groups give to staffing problems are very interesting both to the people who do the hiring and those who are being hired.

The section on "Job Placement and Training for the Mental Hospital Patient" would be good if it did nothing more than strike out the word "physically" from "Employment for the Physically Handicapped" so that it reads "Employment for the Handicapped."

I hope that the Mental Hospital Institute will continue to publish the proceedings of these institutes so that they may be available to all of us who are unable to attend.

Don't just ask for "mineral oil"
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THE BEST IN MINERAL OIL

The Psychiatric Aide, His Part in Patient Care, by Alice Robinson, R.N. 186 pages. J. B. Lippincott Co., 2083 Guy St., Montreal, P.Q. 1954. Price $3.00.

Reviewed by Roxey Cook, Clinical In-

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structor, Provincial Mental Hospital, Ponoka, Alta.

The contents of the book are presented in simple, concise form with freedom from too much theoretical and abstract material, which makes it easy to read and understand. There is a close correlation between the fundamental psychological principles and the practical problems encountered in the care of the mentally ill. Frequent illustratrations from the psychiatric aide's everyday experiences with his patients not only make the psychological aspects more meaningful but also enhance the degree of interest. The feelings of the patients and the aide in their daily relationships are clearly described. It is also pointed out that emotional responses to various situations affect the individual working with the patient in such a way that his work may be constructive or destructive.

The common emotional responses to needs — fear, anger, grief, love, and hate — are discussed. The aide, through a consistent attitude of quiet friendly interest, conveys his understanding and acceptance of the patient's expression of feelings. His ingenuity is used in providing healthy ways to redirect unhealthy responses.

In special therapies, attitudes, recreational and occupational activities are stressed. Specific routines are omitted.

The patient's "home" must be clean, not "too orderly", and safe (emotionally and physically). The atmosphere must be tension-free with a prevailing feeling of understanding cooperation. Care is given to the total personality — not a "diagnosis." Emphasis is placed on emotional aspects but physical problems are of equal importance.

The author has definitely succeeded in her purpose to provide a text "which may be expected to help the psychiatric aide to a better and richer understanding of himself and his patients." Many important factors have, of necessity, been omitted in the interests of clarity and readability. Despite these omissions, the book would make a worthwhile reference for student nurses and others interested in the care of the mentally ill.

Introduction to General Pathology, by Myrtle H. Coe. 106 pages. Burgess Publishing Company, 426 S. Sixth St., Minneapolis 15, Minn. 1954. Price $2.25.

Reviewed by Mrs. Frances Rosenfield. 937 Avenue Road, Toronto 12, Ont.

In her introduction, the author states that it is necessary for the nurse to understand the nature of disease so that she may be able to comprehend what is going on within the body when a patient manifests disease symptoms and thus develop a safe and in-

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AT ALL DRUG COUNTERS

telligent plan of nursing care. This text, actually a concise course in general pathology, brings to the nurse the essential knowledge needed to achieve those aims.

Written in a simple style, it could be used as an elementary textbook for student nurses. The content of each chapter is clearly marked and the continuity of material well-planned. There might have been a greater number of illustrations included throughout the entire book. There are seven chapter headings used which deal respectively with: tissue development and structure; conditions involving changes in cell growth and size; degenerative changes, disturbances of metabolism, and abnormal pigmentation; disturbances of blood vessels and circulation; inflammation; infection; immunity and hypersensitivity; tumors. The last chapter has a particularly interesting summary of the etiology of tumors, and an excellent classification.

This book should be a valuable addition to a nurses' library as a reference. It should be of considerable aid to the student nurse during her study of the basic sciences.

A Handbook of Pediatrics for Nurses in General Training, by Q. M. Jackson, S.R.N. 100 pages. Clarke, Irwin, & Company Limited, 103 St. Clair Avenue, W., Toronto 5, Ont. 1952. Price $1.75.

Reviewed by Rita Petrone, Supervisor, Pediatric Dept., St. Joseph's Hospital, Port Arthur, Ont.

The author in presenting a handbook for reference purposes has unfortunately stressed definitions and conditions, and relegated the equally important details of procedures to the position of minor importance.

There is a certain lack of precision apparent from time to time. For example, in the discussion of congenital torticollis, the suggested procedure of manipulative stretching and exercise or the wearing of a Trethowan collar would be the recommended treatment at birth rather than at three years. In the diagnosis of congenital syphilis which is listed under "Neonatal Conditions" the statement is made that "the second teeth may be notched" whereas the second teeth play no part in neonatal conditions. A handbook for student nurses is certainly no place to advise the administration of a "dosage" of intramuscular streptomycin. The final chapter on routine procedures is well and carefully written giving an indication of the author's pediatric experience. Some of its value is lost because the methods and equipment are now outdated.

In conclusion, the "Handbook of Pediatrics for Nurses" is reduced in usefulness because of lack of precision and illustrations.

Cheese

One of the oldest foods known to the human race, cheese has accompanied the civilization of mankind. Some primitive savage first discovered it: noticing how milk carried in an animal skin became curdled or "renneted" by the acids in the hide, he tasted the thick creamy result, and found it good. Cheese had come to stay.

The first written mentions of cheese as a regular article of diet occur about 1400 B.C. The Ancient Egyptians made cheese from sheeps' milk, and the Ancient Greeks from the milk of both sheep and goats. Indeed, the Greeks must have depended a great deal on it, for apart from meat and cereals, it is the only common foodstuff mentioned by Homer. The early Jews knew and loved cheese, too, and all the references in the Bible to "butter" may be more correctly

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translated as "curdled milk." At any rate, they refer to a simple cream cheese made by curdling. It is fairly certain that the delicacy served to Sisera by Jael "on a lordly dish" before she killed him was a piece of choice cheese. Only the methods of cheese-making varied slightly from the modern ones: Aristotle mentioned the renneting of milk with the sap of fig-trees.

The Romans who were expert cheese-makers flavoring their products with herbs and spices and smoking them over wood fires, took the art to Britain. Specimens of Roman cheese dug up in Saxon and later ruins may still be seen in museums.

The milk from which cheese is prepared need not necessarily come from cows; the milk of sheep, goats, mares, reindeer, even camels, makes excellent cheeses of varying flavors and types. Roquefort cheese is an example of cheese made from a mixture of sheep and goats' milk, while Gruyère was originally made from goats' milk but is now made from cows' milk. There are at least 150 different kinds of vat cheese known in Europe and America, not counting numerous "processed," "cream" or "fancy" cheeses, which are increasing in popularity...

As a daily food, of course, cheese is unsurpassed, a fact recognized long before medieval times. It is true to say that together with rye bread and ale, cheese kept alive the vast proportion of the English people during the terrible famines of the Middle Ages and after... The most cheese-conscious country in the world was, and still is, Switzerland, where there is now a "Cheese University" granting diplomas or degrees in cheese-making...

The value in cheese comes from its peculiar status as a living food, like milk or honey. The bacteria in cheese, long the subject of jokes, are in reality its life-blood... According to Dr. Adamez of the Sorbonne, Paris... there are more organisms in a quarter pound of kept cheese than there are people on the globe.

Cheese was one of the last common foods

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to be successfully canned... Probably the latest development in modern cheese-making is the use of radio waves for speeding up the otherwise lengthy maturing processes of fresh-pressed cheeses . . .

There are fashions in cheese, too... The pungent, slightly sour odor of Limburger is not appreciated by Americans, although in other countries it is considered part of the enjoyment from the food. So an odorless Limburger is now made in the U.S....

— CLIVE BEECH
The British Journal of Nursing

Ontario

The following are staff changes in the Ontario Public Health Services:

Appointments — *Mary (Dibden) Adams* (Health Visitor and Queen's Institute of Dist. Nursing cert.) to Wentworth Co. School Health Service. *Anne Allen* (Wellesley Hosp., U. of Toronto gen. course) formerly with Fort William and District H.U.) and *Phyllis Campbell* (Chatham Public Gen. Hosp., U. of West. Ont. cert. course) formerly with Huron Co. H.U. to York Co. H.U. *Gladys Babington* (Owen Sound Gen. and Marine Hosp., U. of T. gen. course) formerly with Owen Sound B.H. to Wellington Co. H.U. *Mary Berthe* (U. of Ottawa S. of N., cert. course) and *Helen Kennedy* (Ottawa Civic Hospital, Queen's U.) both to Stormont, Dundas and Glengarry H.U. *Margaret Donevan* (Kingston Gen. Hosp., B.N.Sc. Queen's U.) formerly with E. York-Leaside H.U. to Forest Hill Village B.H. *Barbara Gallivan* (B.A., St. Michael's Hosp., U. of T. gen. course) formerly with Oxford H.U.; *Virgina Hamilton* (B.N.Sc. Queen's U.) formerly with Kingston B.H.; *Dorothy Wick* (Women's College Hosp., U. of T. gen. course) formerly with York Township B.H. and *Elizabeth Wilson* (Toronto East Gen. Hosp., U. of T. gen. course) all to Toronto Dept. of P.H. *Carrie Genik* (Royal Alex. Hosp., Edmonton, U. of T. gen. course and Advanced Course in Admin. and Supervision) formerly with Belleville B.H. to Dundas B.H. *Marie Hurteau* (Hotel Dieu Hosp., Montreal, B.Sc.N. U. of Ottawa) formerly with Prescott and Russell H.U. to Ottawa B.H. *Floris King* (B.Sc.N. U. of T.) and *Mary (Daigneault) Doyle* (St. Jos. Hosp., London, U. of T. gen. course) formerly with Toronto Dept. of P.H. to Etobicoke Township B.H. *Jean Laughren* (Toronto Gen. Hosp., U. of T.

gen. course); *Lassy Malowany* (Winnipeg Gen. Hosp., U. of T. gen. course) formerly with Ottawa B.H. and *Dorothy Nakamachi* (St. Paul's Hosp., Vancouver, U.B.C. p.h.n.) formerly with St. Catharines-Lincoln H.U., all to North York Township B.H. *Catherine (Johnston) Mowbray* (B.Sc.N. U. of T.); *Grace Arnot* (Toronto E. Gen. Hosp., U. of T. gen. course) and *Fenna Dykstra* (Deaconesses Institute, Holland, Groningen University) formerly with Chatham B.H., all to Scarborough Township B.H. *Martha (Saari) McNeely* (Toronto West. Hosp., U. of T. gen. course) to East York-Leaside H.U. *Helen MacKinlay* (Victoria Hosp., London, U. of West. Ont. cert. course) to Lambton H.U. *Beverley Pachal* (St. Paul's Hosp., Saskatoon, U. of Alberta p.h.n.) to Owen Sound B.H. *Patricia Pietersma* (St. Jos. Hosp., London, B.Sc.N. U. of West. Ont.) and *Betty Petherick* (St. Jos. Hosp., London, B.Sc.N. U. of West. Ont.) to Elgin-St. Thomas H.U. *Elsie Raikes* (B.A., T.G.H., U. of T. gen. course) formerly with Northumberland and Durham H.U., and *Jessie Yule* (T.G.H., U. of West. Ont. cert. course) to Simcoe Co. H.U. *Nellie Shamas* (Women's College Hosp., U. of T. gen. course) to Peel Co. H.U. *Hilda (Pletch) Shilliday* (Stratford Gen. Hosp., U. of West. Ont. cert. course) and *Isabel (Taylor) Oliver* (Hosp. for Sick Children, U. of West. Ont. cert. course) formerly with Wellington Co. H.U. to Middlesex Co. School Health Service. *Annie Sorbie* (Health Visitor and Queen's Institute of District Nursing cert.) and *Sally (Stillman) Wilkins* (St. Michael's Hosp., U. of T. gen. course) to Oxford H.U.

Resignations — *Marjorie Allen* from Etobicoke Township B.H. *Madelon (Milroy) Bagg* and *Olive Erb* from York Co. H.U. *Elsie (Couchman) Cook* from Windsor B.H. *Dorothy Deeble* from Muskoka District H.U. *Ina Dickie* from Simcoe Co. H.U. *Edith Holrub* from Fort William and District H.U. *Therese Langevin* from Prescott and Russell H.U. *Olga Wallace* from Michipicoten Township B.H. *Mary Willsher* from Ottawa B.H.

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments — Brantford: *Eleanor*

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Wearring (Gen. Hosp., Hamilton). Edmonton: *Sylvia Holmes* (Univ. of Alta.). Hamilton: *Frances Hewlett* (St. Jos. School of Nursing, Hamilton). North Vancouver: *Doreen Benham* (Univ. Hosp., Edmonton). Ottawa: *Audrey Smith* (Sherbrooke Hosp.). Pembroke: *Shirley McCann* (Saint John Gen. Hosp., N.B.) Saskatoon: *Dorothy Rudman* (St. Jos. Hosp., Victoria). Vancouver: *Dorothy Brown* and *Patricia Burgoyne* (both V.G.H.). Yarmouth: *Mrs. Margaret Allen* (Gen. Hosp., Yarmouth).

Transfers — *Dorothy Brown* from Preston to nurse in charge, Welland, Ont. *Marian Brown* from Vancouver to nurse in charge, Carleton Place, Ont. *Mrs. Maureen Barnes* from Vancouver to Victoria. *Isobel Simister* from Timmins, Ont., to nurse in charge, Calgary.

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News Notes

ALBERTA

District 3

Calgary

The first meeting of the fall season was held at the School for Nursing Aids in September. Miss E. Shaw, president, announced that two educational bursaries of $100 had been awarded to prospective student nurses. The recipients are selected by the educational directors of the Calgary General and the Holy Cross Hospitals. This is the second year that bursaries have been awarded, the money having been raised at a bursary tea held earlier in the year.

Mrs. G. Duthie reported on the work of her committee which had decorated a car representing the A.A.R.N. in the 50th Jubilee Parade, which was reviewed by Prime Minister Louis St. Laurent.

There was some discussion regarding a notice of motion being brought forward to reduce the number of meetings held each year. The group now meets every month from September to June inclusive. The annual meeting will be held at the Holy Cross Hospital in October and will be a supper meeting.

High River

A regular meeting of the chapter was held recently in the Nurses' Residence with Mrs. Goodwin presiding. There was an attendance of twenty-six members and six visiting nurses.

Dr. Lander from Turner Valley was the guest speaker. He gave a particularly interesting address on the subject of "Psychosomatics" emphasizing the effect of an individual's state of mind on his good health or lack of it.

District 7

Westlock

The chapter has had numerous activities during the past months. Members assisted with the functions on Hospital Visiting Day. A float representing the T.B. Clinic was entered in the Sports Day parade. A very successful blood donors' clinic was held in September. A Telephone Bridge was planned for October and the members are looking forward to another active season.

A scholarship was awarded by the chapter to K. Ziebro, a student nurse. A farewell party was held in honor of Mrs. Steininger.

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Newfoundland, Nova Scotia, and Prince Edward Island: C. M. Knowlton, 147 Granville Avenue, Halifax, Nova Scotia.
Ontario: Jack Hood School Supplies, 91 Erie Street, Stratford, Ontario.
Quebec: C. R. Senecal, 3288 Van Horne Avenue, Montreal, Quebec.
Saskatchewan: Commercial Printers Ltd., 1935 Albert St., Regina, Saskatchewan.

BRITISH COLUMBIA

TRAIL

A regular meeting of the chapter was held recently with Mrs. Ross presiding and 17 members present. Two new members were introduced.

A rummage sale in November was planned. A request for volunteers for district committee work is to be considered later.

The guest speaker, Dr. Dorgelo, gave a very interesting address on poliomyelitis.

MANITOBA

FLIN FLON

The Graduate Nurses' Association has had another very active year with a total membership of 95 and an average attendance of 35 at regular meetings.

The annual cancer fund tag day was held in September. Donations amounting to $1,164 were collected to further the work of the Cancer Institute. The association's big money-raising venture is the Charity Ball in October. This is usually the opening dance of the winter season.

Earlier this year a social evening was held for one of the members who had had the misfortune to lose a considerable part of her household effects in a fire. A purse of money was presented to her.

Two farewell teas were held, one in June for Misses M. Lee and B. Small, and one in August for Mrs. Jenner and Miss McIntosh. Souvenir spoons were presented to to the honored guests.

Guest speakers gave interesting addresses at general meetings on nutrition and the RH factor.

NEW BRUNSWICK

MONCTON

Plans for the annual meeting of the N.B. A.R.N. were discussed at a recent meeting of the chapter. The report of the Nurses' Registry by Mrs. E. Stone showed a very busy month. Reporting from the nursing education committee, Mrs. L. Colwell indicated that the following graduates from the local hospitals will undertake post-graduate study this fall: Miss Larracey, Miss Arseneau, teaching and supervision and Mrs. Bourgeois, clinical teaching — all from Hotel Dieu; Miss Jenkins, Miss Johnson, teaching and supervision, and Miss MacCallum, pediatric study — all from Moncton Hospital. It was reported that Moncton Hospital students have published their first Year Book.

Dr. Ibbotson, assistant radiologist at Moncton Hospital, was the guest speaker. He gave a most interesting and informative address on the "Cobalt Bomb."

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Moncton Hospital

At a recent meeting of the Nurses' Hospital Aid it was announced that Mrs. K. Mayhew would assume presidency for the remainder of the term. She replaces Mrs. G. Shaw who has moved from the city. Mrs. Shaw was presented with a gift prior to her departure. A rummage sale and a cooking sale were scheduled as part of the fall activities. Miss K. Richardson reported regarding the model of the brain and the classroom chairs recently presented to the hospital by the Aid.

The closing meeting was held at the nurses' cottage, Shediac Cape. The cottage, given to the nurses as a summer home by Mr. L. Lockhart, chairman of the hospital board, was a source of much enjoyment to students, staff and guests during the summer.

NEWCASTLE

The annual meeting of Miramichi Chapter was held in the Nurses' Residence, Miramichi Hospital, on September 21.

The reports of the committees were read and approved. Miss Pearl Allison was nominated as the delegate of the chapter to the annual meeting of the N.B.A.R.N. to be held in Moncton, October 19-20.

Miss Lynds announced the opening of a prenatal clinic that will be held at the Miramichi Hospital the first and third Monday of each month. Mrs. B. Morris, P.H.N., who is in charge of this clinic, gave a resumé of the classes to be held and explained the aims of the clinic.

The nominating Committee brought in the following slate of officers for 1955-57: President, Miss H. J. Lynds; 1st vice president, Sister Nowlan; 2nd vice president, Miss R. Schofield; secretary, Miss B. Russell; Treasurer, Mrs. S. Whitney.

The conveners of the committees were named with power to choose their own committee members: Nursing Service, Mrs. Goody; Nursing Education, Sister MacKenzie; Legislation, Sister Sanford; Publicity, Mrs. Paul; Entertainment: Chatham, Miss I. Loggie; Newcastle, Miss Schofield. Miss B. Martin is convener of a committee to study a questionnaire submitted by the provincial association to be reported on at the annual meeting.

SAINT JOHN

St. Joseph's Hospital

J. McKnight and E. Jefferies are on the staff of San Joaquin Hospital, French Camp, Calif. C. Weatherby has resigned from the staff of Presbyterian Hospital, N.Y. and plans to resume private duty here. J. Richardson is stationed at *Strathcona* with the R.C.N. M. Perry and S. Smith have joined the R.C.A.F. and are stationed at St. Jean and Calgary respectively. I. Ryan is attending University of Toronto, enrolled in the course in nursing education. D. Warner

is taking the course in public health nursing at the University of Ottawa. G. Mahoney recently resigned as assistant supervisor. She has been replaced by T. Martin. M. McDermott has resigned as supervisor of the Central Dressing Room and has been replaced by M. Dalton, with S. O'Leary as her assistant. B. McGuire has resigned as assistant of the Maternity Dept. Sr. Concepta has been transferred to Holy Family Hospital, Prince Albert, Sask. She has been replaced by Sr. Rose Katherine.

ONTARIO

District 5

Toronto

Women's College Hospital

The alumnae association resumed activities for the winter months at a recent meeting in Burton Hall. Mr. C. B. Hassing, a representative of Henry Birks' Ltd., was the guest speaker and discussed fine china and crystal.

There have been several reunions. W. (Gorman) Anderson, E. (Duffield) Buckham, D. (Greenwood) Kervo and A. Lyle attended the class of '46 reunion. Members of the classes of '30-'31-'32 held a combined party honoring J. (Townsend) Windsor.

K. (Salvaldsen) Johansen is continuing her studies at Oslo University where she is enrolled in the public health course. E. (Elliott) Smith is working in India. M. Dahlgren is doing part-time nursing at a base hospital in Germany.

District 8

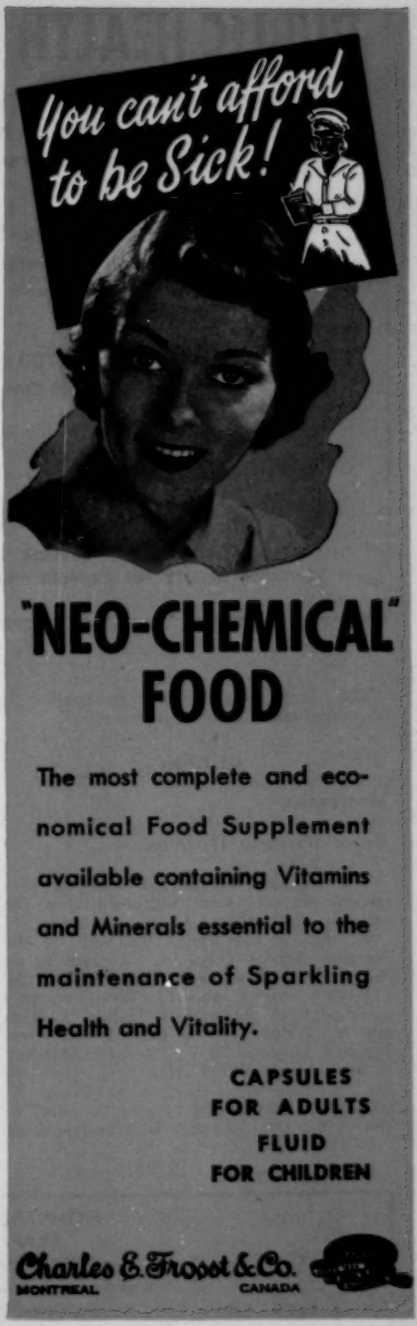
Ottawa

Civic Hospital

The prize winners of the year's graduating class were as follows: E. C. Langmyhr — E. Norman Smith prize and prizes in medical and obstetrical nursing; B. A. Learoyd — "best chum" prize; S. A. Blackmore —highest standing in theory; L. E. E. Howard and N. J. Robertson — highest standing in gynecological nursing; L. Aramet and S. A. Blackmore — pediatric nursing prize. E. Gendron and R. Laushway were the recipients of the bursaries donated by the hospital for a year's post-graduate study in nursing education at an approved university.

An alumnae chapter has been formed in Sudbury. Officers for the year are: M. (Kirk) McLeod, president; A. (Kedey) Merwin, first vice-pres.; J. Blanchard, 2nd vice-pres.; P. Fosten, secretary; A. (Veinotte) Dewar, treasurer. The first meeting had an attendance of 19 members.

M. (Connelly) Braddock is matron of Union Hospital, Imperial, Sask. K. (Connelly) Smylie is engaged in part-time nursing in the same town.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The alumnae association is holding a rummage sale late in November.

QUEBEC

MONTREAL

Royal Victoria Hospital

The members of the fall class of preclinical students were welcomed at a tea early in September.

H. Adams has joined the staff of the Nursing School Office. L. Wallace is on the staff of Saskatoon City Hospital. N. (Hartle) Ritchie and D. Willis recently resigned from the staff. I. Halley, S. Ness and V. Wright are on the staff of Presbyterian Hospital N.Y. Margaret Marshall is head nurse, Ward E with C. Tobin as her assistant. S. Calder is on Ward N, while C. Campbell has joined the staff of the A.M.I. M. Monahan is attending University of Rochester where she is taking the course in public health. C. Grimson is replacing her on Ward D. L. Wright, is with the Health Department, Victoria. D. Liddell is working in a doctor's office in Windsor, Ont. E. Bell Rogers is teaching in Willowdale, Ont. M. Holder is working with the Queen's Nurses, London, Eng. G. Purcell has assumed her duties as supervisor of R.V.M.M.H. B. Pratt, D. Leslie and A. Buchachan are attending McGill School for Graduate Nurses this year.

M. Hudson is on leave from Ceylon where she will be stationed for another term of duty with WHO. M. Dolphin was a recent visitor en route to Syria with WHO. M. (Campbell) Coleman (1909) was also a recent visitor.

The alumnae association resumed activities for winter months at a recent meeting in the Nurses' Home. Dr. Tweedie was the guest speaker for the evening. The P.E.I. chapter have also commenced their activities for the season.

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Supervisor & General Duty Nurses for 40-bed General Hospital. Apply Supt., General Hospital, Kincardine, Ontario.

Obstetrical Supervisor for 48-bed maternity dept. in 486-bed general hospital. Supervision of case rooms, nursery and wards. School of Nursing. Salary: $265 basic, with credit for experience and p.g. study. 28 days annual vacation. 10 statutory holidays. Cumulative sick leave. 40 hr. wk. B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

Pediatric Supervisor for small ward in Teaching Hospital. **Dietitian** for newly built hospital of 130 beds. **General Duty Nurses** for rotation duty. New residence provided. Salary for above three according to experience. Apply Supt., Prince County Hospital, Summerside, Prince Edward Island.

Supervisor & Public Health Nurses (qualified) for Porcupine Health Unit. 5-day wk. 4 wk. vacation. 18 days sick leave annually. Car provided. Good working conditions. Apply Secretary Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

Psychiatric Nurse to assume position as Head Nurse & Clinical Supervisor of new 38-bed Psychiatric Unit in a 500-bed General Hospital. An excellent opportunity for a Psychiatric Nurse who wishes to assume leadership in developing the policies, procedures & teaching program of this new Psychiatric Unit. Patients treated only by psychiatrists. The most modern facilities & treatment methods. Cooperative administration. Bachelor's Degree required plus Psychiatric experience. Salary commensurate with experience & abilities. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

Supervisors, Head Nurses, Team Nurse Leaders, General Duty Nurses for new 237-bed fully modern hospital. Progressive personnel policies. Educational opportunities, Marshall College. 44-hr. wk. with 40-hr. optional at adjusted salary. Part-time positions for students. Salaries: Supervisors, $275 to $325. Head Nurses, $250 to $280 depending on qualifications. Staff Nurses, $240 to $270, 3 yr. period. For full particulars apply Director of Nursing, Cabell Huntington Hospital, Box No. 492, Huntington, West Virginia.

Assistant Director of Nursing for 87-bed General Hospital in Central British Columbia. Duties to commence Jan. 1. Living accommodation available. Apply Administrator, Prince George & District Hospital, Prince George, British Columbia.

Operating Room Supervisor, Dietitian & Staff Nurses (2). Good salary & personnel policies. Apply Director of Nurses, General Hospital, Parry Sound, Ont.

EMPLOYMENT OPPORTUNITIES FOR GRADUATE NURSES

Due to the opening of a new wing in a well-equipped, new 125-bed hospital in Suburban Toronto. Enjoy the congenial working conditions of a smaller institution with the advantages of locating in metropolitan Toronto. Residence accommodation optional.

SALARY RANGES

GENERAL DUTY	$205 - $275 monthly
HEAD NURSES	$225 - $295 monthly
SUPERVISORS	$240 - $310 monthly

Apply:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL,
200 CHURCH ST., WESTON, TORONTO, ONTARIO

Instructor in Obstetrical Nursing. No administrative duties. 117 adult beds — 117 bassinets. 3-yr. school with an enrolment of 300 students. Instruction & clinical experience provided for neighboring university school of nursing. 44-hr. wk., paid statutory holidays, 1 mo. vacation. Cumulative sick leave, retirement plan & other attractive personnel policies. Minimum qualifications: 1 yr. post-graduate course in teaching & supervision & successful experience in obstetrical nursing required. Apply Purchasing Agent, General Hospital, Hamilton, Ont.

Obstetrical Clinical Instructor for School of Nursing with capacity 195 students attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working towards degree. Located in "all American City" of 120,000. in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

Clinical Instructor in Obstetrical nursing for dept. with 26-beds & **Supervisor of Nurseries** for dept. with 30 bassinettes. Duties to include teaching & supervision of student nurses. University post graduate course & experience preferred for both positions. Apply Director of Nursing, General Hospital, Oshawa, Ont.

Applications are invited for the position of Instructor for the School of Nursing in 138-bed Hospital. This school is affiliated with Montreal hospitals & with the teaching schools associated with McGill University. For particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

Nursing Arts Instructor for School of Nursing with capacity 195 students attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working toward degree. Located in "all American City" of 120,000. in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

Instructor to teach anatomy and physiology, microbiology first term, followed by surgical nursing lectures and clinical supervision on surgical wards. Starting salary: $255; $10 for 2 yrs. experience; $10 yearly increments; 1½ days sick leave, cumulative; 10 statutory holidays; 40-hr. wk; 1 class per yr. in September. Apply to: Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

Head Instructor for Training School to teach Sciences. 86-bed hospital; 30 students. Complete maintenance provided in comfortable suite. Apply, stating qualifications & salary expected, A. J. Schmiedl, Sec. Manager, General Hospital, Dauphin, Man.

Clinical Instructor in Pediatrics. Modern 450-bed Hospital. Maximum of 90 Students — 1 class a yr. Excellent personnel policies. Apply Director of Nursing Education, Kitchener-Waterloo Hospital, Kitchener, Ont.

Public Health Nurse for Health Unit adjacent to Edmonton. Generalized program. Minimum salary: $2,700 with annual increments of $150 x 3 & $300 x 1. Starting salary by arrangement. 3 wk. annual vacation. Pension plan, group hospitalization benefit, adequate sick leave. Car furnished on duty. Apply M.O.H., Stony Plain, Lac Ste. Anne Health Unit No. 17, Stony Plain, Alberta.

UNIVERSITY HOSPITAL

Requires

ADMINISTRATIVE SUPERVISORS

to organize the departments of Pediatrics and Surgery in new hospital. Salary $240.00 to $300.00. Good personnel policies.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL, SASKATOON, SASK.

Public Health Nurse — Starting salary: $2.724 with annual increases over 3 yrs. to $3,108 per annum. Previous experience qualifies for a higher salary. Cost transportation refunded after working 3 mo. Car allowance or free transportation while on duty. Pension plan after 3-yr. service. Apply, stating qualifications & experience to Arthur H. Evans, Sec. Board of Health, Port Arthur, Ont.

Public Health Nurses (4), North York Township, adjacent to Toronto. Population 150,000. New salary range now effective, $3,120-3,640 plus $60 monthly car allowance. 4 wk. vacation with salary. Free hospitalization ins., Group life ins., sick pay & pension plan benefits. Appointment effective November 1 or December 1. For further details please contact Dr. Carl E. Hill, Med. Officer of Health, 5248 Yonge St., Willowdale, Ont.

Public Health Nurse for generalized program in rural & semi-urban area adjacent to Metropolitan Toronto. Excellent working conditions including pension plan, group ins. & transportation arrangements. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ontario.

General Duty Nurses for 430-bed hospital; 40-hr. wk. Statutory holidays. Salary: $235-268. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

General Duty Nurses for all departments. Gross salary: $200 per mo. if registered in Ontario $190 per mo. until registration has been established. $20 per mo. bonus for evening or night duty; annual increment of $10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing, General Hospital, Oshawa, Ont.

General Duty Nurses. Salary: $230-$270, $10.00 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, (1) mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

REGISTERED NURSES

$2,430 - $3,120

ACCORDING TO QUALIFICATIONS

for

SUNNYBROOK HOSPITAL, TORONTO

and

WESTMINSTER HOSPITAL, LONDON

DEPARTMENT OF VETERANS' AFFAIRS HOSPITALS

Application forms, available at your nearest Civil Service Commission Office, National Employment Service & Post Office, should be forwarded to the Civil Service Commission, 25 St. Clair Ave., E., Toronto 7, Ontario.

Infirmières demandées par

LA SOCIÉTÉ CANADIENNE DE LA CROIX-ROUGE

- **Service général dans les avant-postes hospitaliers.**
- **Postes d'infirmières surveillantes et infirmières visiteuses dans les avant-postes infirmiers.**
- **Service de Transfusion.**
- **Les infirmières, possédant un diplôme reconnu par l'Association des Infirmières du Canada, devront faire parvenir leur demande d'emploi à l'adresse suivante:**

DIRECTRICE NATIONALE, SERVICE DU NURSING,
LA SOCIÉTÉ CANADIENNE DE LA CROIX-ROUGE,
95 RUE WELLESLEY, TORONTO 5, ONTARIO, CANADA.

Inquiries are invited from Graduate Nurses for General Staff Duty in a new 300-bed hospital to open this fall. Initial gross salary: $225 per mo. with merit increases to $250 per mo. 44-hr. wk. Good personnell policies. Information available re living accommodation. Apply giving qualifications & references to Director of Nurses, Sudbury Memorial Hospital, Regent St. South, Sudbury, Ont.

Graduate Nurses for General Staff Duty in 350-bed Tuberculosis Hospital in Laurentian Mts. For further information, apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Quebec.

Graduate Nurses for 100-bed West Coast General Hospital. Salary: $250 per mo. less $40 for board, residence, laundry. 3 annual increments; $10 per mo. night duty bonus. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance up to $60 refunded after 1st yr. Apply Director of Nursing General Hospital, Prince Rupert, B.C.

Graduate Nurses (3) for 24-bed hospital. Salary: $230 per mo. if B.C. registered; less $40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience, Matron, Terrace & District Hospital, Terrace, British Columbia.

Graduate Nurse for 20-bed hospital. Salary: $190 plus full maintenance. Usual holidays with pay & sick leave. Modern nurses' home. Apply Union Hospital, Vanguard, Sask.

Registered Nurses (2) for 50-bed hospital. Basic salary $180 per mo. plus maintenance, $5.00 increase every 6 mo. for 2 yrs. 44-hr. wk., 3-wk. vacation with pay after 12 mo. service. 10 statutory holidays. For further information apply Matron, Municipal Hospital, Wainwright, Alberta.

General Duty Nurses for large General Hospital in rapidly growing industrial city. Good working conditions, modern equipment. Generous personnel policies include paid vacation, sick leave & statutory holidays. Uniforms laundered. Residence facilities available at nominal charge. Apply Purchasing Agent, General Hospital, Hamilton, Ont.

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FOR THE POSITION OF SUPERINTENDENT OF NURSES

for 42-bed General Hospital in Mennonite town 40 miles from Winnipeg

Training school for L.P.N., 44-hr. week, usual holiday & sick leave benefits, private room in new residence. No business or administrative responsibilities, just supervision of nursing care.

BEST WAGES WILL BE PAID

We also have openings for R.N.'s for general duty

Please state wages expected

APPLY JAC. M. KLASSEN,
Administrator, Bethesda Hospital, Steinbach, Man.

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GRADUATE NURSES FOR GENERAL DUTY

Where? Jeffery Hale's Hospital

Why Unique? Only English speaking hospital & training school in Quebec City

For information write:

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Baker Memorial Sanatorium, Calgary, Alberta offers to Graduate Nurses a 6-mo. post-graduate course in Tuberculosis. Maintenance & salary as for general staff nurses. Opportunity for permanent employment if desired. Spring & Fall Classes. Further information on request.

The Vancouver General Hospital invites inquiries from graduate nurses for general staff positions. Salary: $235.50 per mo. as minimum & $273.75 as maximum, plus shift differential for evening & night duty. 40-hr. wk. Temporary residence accommodation is available. Applicants not registered in B.C. should forward a letter of acceptance of registration in B.C. from the Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Apply Personnel Dept., General Hospital, Vancouver, B.C.

Registered Nurses for General Duty (2) for 76-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Gross Salary: $200 per mo., perquisites $30, $5.00 increment every 6 mo., 1 mo. annual vacation with pay; 8-hr. day; 44-hr. wk. Sick leave with pay. Apply Matron, Municipal Hospital, Brooks, Alta.

Registered Staff Nurses, immediate appointments, in 511-bed newly enlarged and finely equipped general hospital. Duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics, or contagion units. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial, and educational friendly activities. Living costs reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio and Pittsburg, Pa. Friendly, cooperative work relations and conditions. Progressively advanced personnel policies. Starting salary: $240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact: Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

Registered Nurses for 36-bed General Hospital. Basic salary: $230; increments $10. 40-hr. wk., full maintenance $45. R.N.A.B.C. agreement. Half fare refunded after 6 mo., balance after 1 yr. Apply Administrator, Nicola Valley General Hospital, Merritt, B.C.

Registered Nurses for modern 60-bed General Hospital situated 40 mi. south of Montreal. Salary: $200 per mo. 8-hr. duty; 44-hr. wk; rotating shifts. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

McKELLAR GENERAL HOSPITAL, FORT WILLIAM, ONT.

Requires

CLINICAL INSTRUCTOR IN OPERATING ROOM

Gross salary commensurate with experience, 28 days vacation after one year, 8 statutory holidays, sick leave accumulative to 60 days; Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped and staffed wing with extensive renovation program progressing in the old section.

APPLY DIRECTOR OF NURSING

REGISTERED STAFF NURSES

Required by The Provincial Government of Newfoundland Department of Health

For General Duty in small 6-32-bed hospitals. Salary commences at $2,200 per annum on the scale $2,200-100-2,300.

Accommodation in the hospital $40 per mo. 24 working day vacation. Sick leave with pay. Uniforms & laundry services free. Successful applicants have their transportation paid to the hospital.

Hospitals situated in the coastal regions of the Province & act as the centre of Medical services for a group of settlements.

For further information & application form apply:

Director of Nurses, Dept. of Health, St. John's, Nfld.

Operating Room & General Staff Nurses for 155-bed Acute General Hospital located in famed San Joaquin Valley. Starting salary: $285 per mo., $10 mo. additional for O.R., regularly scheduled increases. 40-hr., 5-day wk. 2 wk. paid vacation after 1 yr., 3 wk. after 5 yrs., 1 mo. after 10 yrs. Travel expenses refunded after 1 yr. employment. Apply Personnel Manager, Community Hospital, P.O. Box 1232, Fresno, California.

General Duty Staff Nurses for 250-bed modern hospital — all departments. Near all New York universities. Excellent salary, bonus 4-12 & 12-8 shifts. Regular increments. 40-hr. wk. Single room in nurses' residence at low rates. Apply Director of Nurses, Lebanon Hospital. Mt. Eden Ave. & Grand Concourse, New York 57, New York.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & post-graduate program. Full Maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

Registered Nurses for modern 44-bed hospital in Southern Ontario. 44-hr. wk., rotating shifts, 3 wk. annual vacation, 8 statutory holidays. New residence under construction. Apply Supt., Haldimand War Memorial Hospital, Dunnville, Ont.

Registered Nurses for General Duty. Initial salary: $200. per mo.; with 6 or more month's Psychiatric experience, $210. per mo. Salary increase at end of 1 yr. 44-hr wk; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

Registered Nurses for new modern 250-bed hospital located near the beautiful Beverly Hills area in sunny Los Angeles, Southern California's most glamourous city. Offers a new kind of opportunity for nurses interested in good patient care & learning about latest techniques. In a relaxed & beautiful atmosphere, work with friendly people, enjoy time off at nearby beaches & resorts. Housing facilities in the neighborhood. Starting salary: $300 per mo. with semi-annual increases for 3 yrs. Generous vacation. 8 paid holidays, sick leave, social security, group ins. & unemployment compensation. Opportunities for advancement. In-service program for R.N. & auxiliary workers. Apply Director of Nurses, Mount Sinai Hospital, 8720 Beverly Blvd., Los Angeles 48, California.

UNIVERSITY HOSPITAL

SASKATOON, SASK.

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty-four hour week. Salary $210.00 to $260.00 gross per month. Differential for evening and night duty.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL, SASKATOON, SASK.

REGISTERED NURSES

FOR

General Duty and Operating Room

Opportunities available at the new

MONTREAL GENERAL HOSPITAL

For full particulars write to:

DIRECTOR OF NURSING, 1650 CEDAR AVENUE, MONTREAL 25, QUE.

Registered Nurse for Semi-Administrative work in 44-bed hospital. Medical & emotional patients. $13 per 8-hr. Apply Harworth Hospital, 531 E. Grand Blvd., Detroit 7, Michigan.

Registered nurse for specialty hospital in Detroit. ($13 per day). **Several wanted for** large Chicago hospital ($12.96 per day). Send snap & write to International Employment Agency, 504 Victoria St., Windsor, Ont.

Registered General Duty Nurse (1). Salary $180 per mo. with full maintenance & annual increases of $10 per mo. for 3 yrs. 3 wk. vacation after 1 yr. duty & 4 wk. annual vacation after 2 yrs. Apply Matron, District Hospital, Shoal Lake, Manitoba.

General Duty Nurse for 17-bed hospital 100 mi. N.E. of Calgary. Salary: **$170 with full** maintenance. $5.00 per mo. increase after 6 mo. service up to 3 increases. 1 mo. **vacation** with pay after 1 yr. Transportation refunded after 6 mo. service. Apply **Municipal** Hospital, Elnora, Alberta.

General Duty Nurses (2) for well equipped small hospital. Salary: $160. 5½ day wk., 8-hr. duty, rotating shifts. Long week-end following night duty. Full maintenance. Apply Supt. Saugeen Memorial Hospital, Southampton, Ont.

General Duty Nurses — We need nurses to assist in caring for our 147 tuberculous patients. If you wish to assist in the development of a good nursing program **please** write stating age, experience & salary expected to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal.

General Duty Nurses for 650-bed teaching hospital in Central California. Salary: $288-337 per mo. 40-hr. wk., liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

Operating Room Nurses, preferably with experience, for 75-bed hospital. Operating unit consists of 2 theatres, emergency treatment & recovery room. Apply Supt., Carleton Memorial Hospital, Woodstock, N.B.

WOODSTOCK GENERAL HOSPITAL

invites applications for

SCIENCE INSTRUCTOR - - NURSING ARTS INSTRUCTOR

PEDIATRIC SUPERVISOR - Graduate of Children's Hospital or with Post Graduate Experience.

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New Wing & Complete Renovation of Old Hospital

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GRENFELL LABRADOR MEDICAL MISSION

The Grenfell Mission operates four Hospitals & seven Nursing Stations in northern Newfoundland & on the Labrador. Here is a wonderful opportunity for valuable experience & an adventurous life. If you are making plans for next year, why not consider this splendid service still carried on in the name of a great man?

For full information please write

MISS DOROTHY A. PLANT, SECRETARY, GRENFELL LABRADOR MEDICAL MISSION
48 SPARKS ST., OTTAWA 4, ONTARIO

Operating Room Nurses, immediate appointments, for 511-bed newly enlarged and finely equipped hospital; 10 operating rooms now completed. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial and educational friendly activities; living cost reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburg, Pa. Friendly and considerate working associates and conditions. Progressively advanced personnel policies. Starting salary: $240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

Maternity Nurses for modern 60-bed General Hospital located 40 mi. south of Montreal. Salary: $155 per mo. 8-hr. duty; 44-hr. wk; rotating shifts. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Staff Nurses for 600-bed General & Tuberculosis Hospitals with School of Nursing. Salary: $288-$341. Shift, special service & educational differentials, $10. 40-hr. wk; 3-wk. vocation; 11 holidays; accomulative sick leave. Apply Associate Director of Nursing Service, County General Hospital, Fresno, California.

Operating Room Scrub Nurses (2) with experience or post graduate course. Salary in accordance with S.R.N.A. schedule, consideration given for preparation or experience. New operating room area near completion. For further details apply Supt. of Nurses, Union Hospital, Moose Jaw, Sask.

Dietitian (qualified) for Teaching Hospital. Opportunity for advancement. Full maintenance. Fare from Canada for accepted candidate. For full particulars, write, giving qualifications & date available, Matron, King Edward VII Memorial Hospital, Bermuda.

Office Nurse, R.N., for general duties. Opportunity for surgical experience if desired. Salary open, determined by experience & qualifications. Secure position. Congenial working conditions. Small Wyoming community. Apply R. E. Kunkel, M.D., Thermopolis Clinic, Odd Fellows Bldg., Thermopolis, Wyoming.

School of Nursing, Metropolitan General Hospital
WINDSOR, ONTARIO

The following positions combining both classroom and clinical instruction will be open August, 1955.

INSTRUCTOR IN PEDIATRIC NURSING
INSTRUCTOR IN SCIENCE AND SURGICAL NURSING
INSTRUCTOR IN HEALTH AND MEDICAL-SURGICAL NURSING

This is a new school of nursing with a curriculum pattern of two years of nursing education followed by one year of guided nursing service. It offers an excellent opportunity for instructors to participate in the development of a sound educational program since the hospital does not depend on students for nursing service during their two educational years.

For further information apply to:

MISS DOROTHY R. COLQUHOUN, DIRECTOR, SCHOOL OF NURSING, 2240 KILDARE ROAD, WINDSOR, ONT.

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4802 TENTH AVE., BROOKLYN 19, N.Y., ULSTER 3-1200

General Duty Staff Nurses, All Shifts

APPLICATIONS BEING ACCEPTED FOR STAFF NURSING & SPECIALTIES

OPERATING ROOM — LABOR & DELIVERY — RECOVERY ROOM

SPECIAL BONUS IS GIVEN FOR ALL SPECIALTY NURSING

No Rotation of Shifts — Opportunities for Advancement
40 Hours er Week — 4 Weeks Vacation
Sick Leave & Paid Holidays

FREE HEALTH SERVICE & HOSPITALIZATION

FREE LAUNDRY SERVICE — REGULAR PERIODIC INCREMENTS

Acting Matron to relieve for 4 months during leave of absence of Matron, starting March 1, 1956. 60-bed hospital with 4 doctors. 2-room suite with bath available in residence. Personnel includes office staff of 3, x-ray & lab technician & housekeeper. Nursing staff consists of registered nurses, certified nursing aides & nursing aide trainees. State salary expected and give references. Position possibly permanent. For further information apply Matron, Municipal Hospital, Elk Point, Alberta.

Nursing Arts Instructor, Clinical Instructor — medical nursing, Head Nurses for General Hospital. Attractive personnel policies. Residence accommodation, if desired. New school unit. Apply Miss M. E. Thompson, Supt. of Nurses, General Hospital, Regina, Sask.

Registered Nurses (2) for 43-bed hospital. Gross salary: $210 per mo. $5.00 increment every 6 mo. to 2 yrs. Separate nurses' residence. For further information apply Matron, Municipal Hospital, Athabasca, Alberta.

Registered Nurses for small new hospital. Salary: $165 per mo. plus single room in attractive new residence, board & laundry. 8-hr. day, 28 days vacation. Apply Supt., Niagara Hospital, Niagara-on-the-Lake, Ontario.

Registered Nurse for 41-bed maternity dept. Special preparation in Case Room Management for position as **Asst. Head Nurse.** Salary in accord with A.N.P.Q. recommendations. Good personnel policies. Apply Director of Nursing, Reddy Memorial Hospital, 4039 Tupper St., Montreal 6, Que.

Registered Nurses (2) for 25-bed hospital. Salary: $210 per mo. Full maintenance $30. 1 mo. vacation & 3 wks., sick leave after 1 yr. service. Located in thriving town with good train & mail service. Apply Sec. Manager, Porcupine-Carragana Union Hospital, Porcupine Plain, Sask.

Registered General Duty Nurses (2) for 30-bed hospital. Salary: $170 per mo. plus full maintenance. Salary subject to increase after 6 mos. with regular annual increase thereafter. 30 days vacation after 1 yr. service. Fully modern nurses' residence. Successful applicants reimbursed rail fare after 1 yr. New 60-bed hospital under construction. Apply, stating age & when available to the Supt., Dist. General Hospital, Dryden, Ont.

Operating Room Supervisor for 200-bed General Hospital. Located in scenic Virginia. New 6-room suite. Good personnel policies. Salary commensurate with preparation & experience. Apply Louise M. Reynolds, Supt., C. & O. Hospital, Clifton Forge, Virginia.

General Duty Graduate Nurses for well equipped 72-bed hospital on B.C. coast. Salary: $222 per mo. less $25 full maintenance. Semi-annual increments. 28 day vacation plus 10 statutory holidays after 1 yr. Transportation advanced if desired. Apply Mrs. Mark, Matron, St. George's Hospital, Alert Bay, B.C.

Graduate Nurses (2) for new model 7-bed hospital in south central Saskatchewan. Salary: $210 plus $5.00 semi-annual increments, less $15 per mo. for room & 25 cents each meal. 3-wks. vacation annually plus statutory holidays. Apply C. Barrett, Sec. Treas., Union Hospital, Rockglen, Sask.

INTRAVENOUS TEAM

Wanted: Nurse with experience in intravenous therapy to head up a proposed intravenous team.

Apply to

DIRECTOR OF SCHOOL OF NURSING, KINGSTON GENERAL HOSPITAL, KINGSTON, ONT.

EMPLOYMENT OPPORTUNITIES FOR GRADUATE NURSES

LOWELL GENERAL HOSPITAL

A 257-bed General Hospital, fully accredited. School of Nursing. Accommodations to live-in available. College community, only 28 miles from Boston.

For further information apply

DIRECTOR OF NURSING, GENERAL HOSPITAL, LOWELL, MASSACHUSETTS

Operating Room Supervisor for active surgical unit of 100-bed Ontario hospital. Approx. 1,800 cases annually. Vacation after 1 yr. service. Sick leave, statutory holidays & Blue Cross plan. Post-graduate diploma desirous but not necessary if experience is adequate. Apply Box No. 1, The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25,

Registered Nurse (1) for new, model, 18-bed hospital. Salary: $200 per mo. ($10 less if not registered in Saskatchewan) & full maintenance. 3-wks. vacation with pay, statutory holidays & sick leave. Comfortable separate residence. Apply G. F. Penson, Sec. Mgr., Union Hospital, Mankota, Sask.

Registered General Duty Nurses (2) for 22-bed country hospital. Salary: $235 per mo. less $30 for complete maintenance in new modern $35,000 nurses' residence. 4-wks. vacation per yr. after 1 yr. employment. 3-wks. sick leave. Daily bus service to Moose Jaw & Regina as well as twice weekly train services. Staff of 15 including 5 registered nurses. For further information apply to Mrs. E. C. Coulson, Nurse Supt., Union Hospital, Central Butte, Sask.

Registered Nurses, one with operating room experience preferred. Duties to commence as soon as possible. Starting salary: $215 for **General Duty Nurses** & $230 for **Operating Room Nurse** gross, less $30 per mo. for maintenance in new modern residence. Increments of $5.00 per mo. at the end of 6 & 12 mos. 1 mo. vacation with pay after 1 yr. service. Good train service. Apply by letter to Sec. J. P. Fawcett, Union Hospital, Unity, Sask.

Registered Nurse to take charge of small hospital. Duties to commence at once. Apply stating qualifications & references to Administrator, District Hospital, Shelburne, Ontario.

Matron for 10-bed hospital. Must be registered nurse. Salary: $275 less maintenance. Apply Mr. J. F. Anderson, Secretary-Treasurer, Siglunes Medical Nursing Unit, Ashern, Manitoba.

The International Council of Nurses invites applications for the post of **Publications Officer.** The selected applicant must have had experience of editing & journalistic work & should preferably be a nurse. Knowledge of languages an asset. Salary: £800 to £1,000 per annum. Appointment to be made within this scale according to experience. Further particulars may be obtained from the Executive Secretary, International Council of Nurses, 19, Queens Gate, London, S.W.7., to whom applications should be sent together with 3 recent references not later than Dec. 31st, 1955. It is hoped to make the appointment early in 1956.

General Staff Nurses

URGENTLY NEEDED

SAINT JOHN GENERAL HOSPITAL, SAINT JOHN, N.B.

GOOD STAFF POLICIES & SALARY

Apply Director of Nursing

SAINT JOHN GENERAL HOSPITAL, SAINT JOHN, N.B.

Official Directory

CANADIAN NURSES' ASSOCIATION

270 Laurier Ave., W., Ottawa

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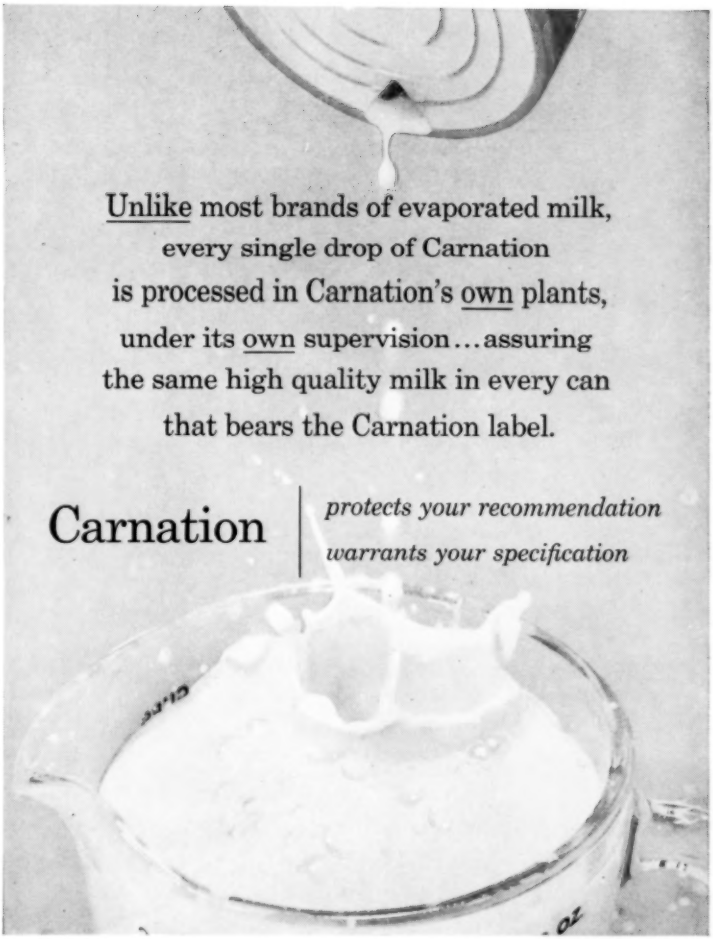
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